MICHIGAN DEPARTMENT OF COMMUNITY HEALTH

ELECTRONIC BILLING MANUAL

December 20, 2001

Michigan Department of Community Health

MDCH

MSA

MEDICAL SERVICES ADMINISTRATION

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FOREWORD

This manual describes how to become an electronic billing agent as well as how to use the MDCH Invoice Processing System for filing electronic claims. It applies to all claims submitted to the Michigan Department of Community Health (MDCH) for:

- Medicaid,
- Children's Special Health Care Services (CSHCS), and
- State Medical Program (SMP).

The Michigan Department of Community Health (MDCH) encourages those providers and agencies who submit claims to MDCH to become electronic billing agents. There are several advantages to billing electronically:

- Electronic claims can be processed and paid much more quickly.
- Electronic claims have fewer errors so bills don't have to be resubmitted.
- Electronic claims can be posted more easily.
- Electronic claims can be used for additional services, such as claim status information.

Becoming an electronic billing agent is easy. Entities (service bureaus or providers themselves) who wish to bill MDCH electronically need to complete only a few steps to become authorized billing agents.

1. Contact the MDCH Automated Billing Unit for an application packet. (See information below.)

2. Complete and submit the forms. (See Section 2, "Authorization to Bill MDCH Electronically.")

3. Receive an identification number.

4. Format and submit test files. (See Section 3, "Testing," Section 4, "Preparing Electronic Files," and Section 5, "Using the Data Exchange Gateway.")

5. Receive full authorization to bill electronically once test files are approved.

Prospective billing agents are urged to review these instructions carefully. Questions can be addressed to the Automated Billing Unit by e-mail or through the information line.

E-mail: AutomatedBilling@michigan.gov

Information Line: 1-800-292-2550

Current electronic billing agents should provide their service bureau identification (ID) numbers when they contact the Automated Billing Program Unit.

1 INTRODUCTION TO MDCH ELECTRONIC BILLING

The electronic billing system is made up of several elements. This section provides an overview of those elements and how the system works.

1.1 ELECTRONIC BILLING SYSTEM OVERVIEW

Electronic billing (also referred to as "automated billing") is made up of two transactions: submission by a billing agent to the **Invoice Processing System,** and the resulting **Remittance Advice** sent to the billing agent. Each is described here.

1.1.1 Invoice Processing System

Claims submitted by electronic file transfer (EFT) are processed through the MDCH Invoice Processing (IP) System, the same system used for processing paper claims.

The IP System consists of several cycles:

- The **daily cycle** is the first set of computer programs to process all electronic (and paper) claims. (Paper claims are first optically scanned and converted to electronic before being processed.) The daily cycle is run four to five times each week. It performs all *intra*-claim editing (e.g., provider and recipient eligibility, procedure validity). All claims are reported out as tentatively approved, rejected, or pended.
- The **weekly cycle** is run once each week using the tentatively approved claims from the daily cycles that were run during the previous seven days. The weekly cycle includes *inter*-claim editing using an historical file of all claims paid during the previous 24 months. Inter-claim editing includes duplicate claims, procedures with frequency limitations, and the number of refills on a prescription. The Provider's Warrant and Remittance Advice are also generated from this cycle. All claims are reported out as approved for payment, rejected, or pended.
- Claims that cannot be processed against the current history file ("**aged claims**") are held for processing against an archived file and are resolved manually. All claims are reported out as approved for payment, rejected, or pended.

Pended claims are reviewed by the MDCH and, after appropriate resolution, these claims are again processed through the daily and weekly cycles as if they were new claims.

All initial claims, replacement claims, and rebillings of previously rejected claims may be submitted as electronic files. The billing agent should refer to the appropriate provider manual, available from the MDCH (see Section 7.2), for instructions.

1.1.2 Remittance Advice

Once claims have been submitted (electronically or on paper) and have processed through the IP system, a paper Remittance Advice is sent to the provider and an electronic Remittance Advice (RA) file is sent to the billing agent. The paper Remittance Advice indicates the status of all the provider's claims received by the MDCH. The electronic RA file covers all claims submitted on both paper and electronically by the billing agent. (Claims rejected due to systems errors do not appear on either the paper or electronic RA.)

The RA file may be used by the billing agent to:

- **Update** the provider's accounts receivable,
- **Maintain** the status of pended claims,
- **Report** to the provider commonly encountered errors that may have been a result of the provider's clerical errors, and
- **Monitor** the agent's own system to ensure that the required editing is performed properly.

1.2 PARTICIPATION

Any billing agent capable of submitting claims on a regular basis may apply to participate in the Automated Billing Program. A billing agent may be either a service bureau or the provider who rendered service to a patient.

The Automated Billing Unit maintains a public listing of currently authorized billing agents who participate in the MDCH Automated Billing Program. A billing agent may request to be included on this listing.

NOTES: The MDCH does not recommend any billing agent nor guarantee the competency of any billing agent on the list.

Information about **all** billing agents can be made available to members of the public who request it, whether or not the billing agent chooses to be included in the public listing.

There is no maximum or minimum number of claim lines that must be submitted by a billing agent.

Every billing agent must pass a systems test under the direction of the Automated Billing Unit before being authorized to submit claims. The purpose of this test is to verify that the billing agent is capable of properly encoding, assembling, and editing the claim data. (This testing procedure is explained in more detail in Section 3.)

1.3 BILLING AGENT RESPONSIBILITIES

A billing agent assumes the following responsibilities to the provider and to MDCH:

a. The billing agent must maintain sufficient documentation to provide a complete audit trail from the provider submitting data, to the billing agent, to the submission of claims for payment. This includes individual claim data, procedure coding, and pricing data if the billing agent maintains such information on file for the provider. This documentation must be available to the MDCH on request. The billing agent must make its software and hardware available for audit on request by the MDCH.

b. The billing agent must be able to identify and reconstruct any claim that was paid by MDCH. This data must be maintained for a period of six years from the date of service.

c. Systematic claim errors generated by the billing agent must be reported to the provider and the Automated Billing Unit immediately. It is the billing agent's responsibility to correct such errors.

d. The billing agent must be able to encode all possible configurations of the claim types submitted. Such configurations include:
   - All applicable data fields,
   - Multiple service lines,
   - Up to 924 characters of remarks, and
   - Attached supporting documentation.

e. The billing agent must perform certain edits on the claim data to ensure validity and mathematical correlation.

f. The billing agent is required to correct any billing errors attributed to the agent or its system.

g. All beneficiary records maintained by the billing agent on behalf of the provider are confidential. This information is not to be divulged to unauthorized persons or agencies.

h. The billing agent must, on request by authorized agents of the state or federal government, make available for examination any record required to be maintained.

i. Examination of any records outside a recipient's period of eligibility, or a provider's enrollment period, requires a release statement signed by the recipient or provider, respectively.

j. Information regarding billing agents is considered available to the public whether or not the billing agent chooses to appear on the public listing at the MDCH Web site.

1.4 AUDITS

Occasionally, a systems audit may be performed by the MDCH. The audit may be one of the following types:

- **Routine** systems test – Claim Files ready for production may be subject to a systems test similar to the initial systems test. (Section 3.2 details the initial systems test.) If the files fail this test, the billing agent will be notified of the problem. Billing agents who fail to correct a problem will have their authorization to participate revoked.
- **Examination** of all software and hardware used in preparing claims, questions to the billing agent's employees, and examination of all claim records. The billing agent may also be required to process test data that is prepared by the MDCH for analysis.

NOTE: Systems documentation supplied by the billing agent, or compiled by the MDCH as a result of an on-site systems audit, is considered confidential.

2 AUTHORIZATION TO BILL MDCH ELECTRONICALLY

Entities that wish to bill electronically must be authorized by the Michigan Department of Community Health. This section describes that process.

2.1 AUTHORIZATION TO PARTICIPATE

Any agent (including providers who bill directly for their services) who wishes to submit claims electronically must be authorized by the MDCH. This section describes the authorization process. Applications and authorization forms are obtained from:

AutomatedBilling@michigan.gov

2.2 APPLYING FOR AUTHORIZATION

A completed **original** application and participation agreement (Figure 2-1, Billing Service Company Certificate) must be on file with the Automated Billing Unit. This agreement must be signed by the billing agent before testing can begin.

2.3 RECEIVING AUTHORIZATION

Once the systems test (described in Section 3) is successfully completed, the prospective billing agent will be issued a written authorization or an electronic mailing (e-mail) to participate in the Automated Billing Program. The authorization will specify the parameters that are unique to the billing agent for producing electronic billings.

A Billing Agent Authorization Form must be completed by <u>each</u> provider authorizing the billing agent to submit claims. Billing agents must have the provider submit the Billing Agent Authorization (DCH-1343) form (see Figures 2-2 and 2-3) immediately on verbal notification of a successful systems test. A DCH-1343 must be also submitted to MDCH by each provider the billing agent serves or by each provider who is new to an authorized billing agent. This form certifies that all services the provider has rendered are in compliance with Medicaid's guidelines. A copy of the form may be obtained from the Provider Enrollment Unit at the address noted in Section 2.4.

Only one billing agent per provider will be authorized to submit the provider's claims on electronic file. The provider's most recently authorized billing agent will be considered the only allowable agent to prepare claims by electronic file. **Authorizations remain effective unless otherwise indicated in writing by the provider**.

STATE OF MICHIGAN

JOHN ENGLER, Governor

DEPARTMENT OF COMMUNITY HEALTH

LEWIS CASS BUILDING
LANSING, MICHIGAN 48913
JAMES K. HAVEMAN, JR., Director

BILLING SERVICE COMPANY CERTIFICATE

The Service Company certifies that all invoice information submitted by the Service Company to MDCH is a true and correct report of information received from the service company's enrolled providers.

The service company understands that payment and satisfaction of claims submitted by the service company to MDCH will be from federal and state funds, and that any false claim, concealment of material facts, or falsified data systems input maybe prosecuted under federal and state law. Any variations between provider billing and service company automated input to MDCH will be considered the responsibility of the Service Company and will be considered grounds for removal from the Automated Billing Program.

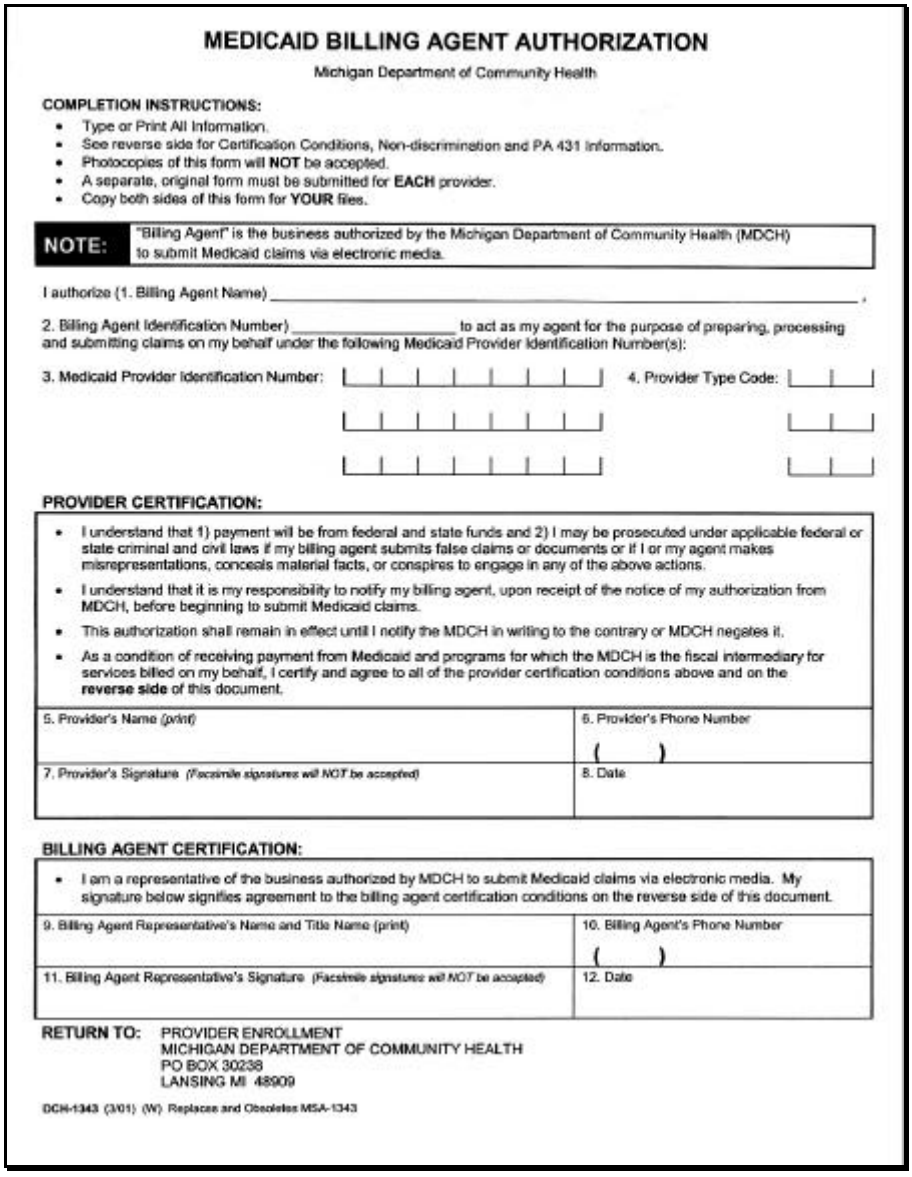
_____
(Name of Authorized Representative - Print)

_____
(Signature of Authorized Representative)

_____
(Name of Service Company - Print)

_____
(Date)

Figure 2-1: Billing Service Company Certificate



MEDICAID BILLING AGENT AUTHORIZATION

Michigan Department of Community Health

COMPLETION INSTRUCTIONS:

- Type or Print All Information.
- See reverse side for Certification Conditions, Non-discrimination and PA 431 Information.
- Photocopies of this form will **NOT** be accepted.
- A separate, original form must be submitted for **EACH** provider.
- Copy both sides of this form for **YOUR** files.

NOTE: "Billing Agent" is the business authorized by the Michigan Department of Community Health (MDCH) to submit Medicaid claims via electronic media.

I authorize (1. Billing Agent Name) _____,

2. Billing Agent Identification Number) _____ to act as my agent for the purpose of preparing, processing and submitting claims on my behalf under the following Medicaid Provider Identification Number(s):

3. Medicaid Provider Identification Number: | | | | | | | | 4. Provider Type Code: | |

PROVIDER CERTIFICATION:

- I understand that 1) payment will be from federal and state funds and 2) I may be prosecuted under applicable federal or state criminal and civil laws if my billing agent submits false claims or documents or if I or my agent makes misrepresentations, conceals material facts, or conspires to engage in any of the above actions.
- I understand that it is my responsibility to notify my billing agent, upon receipt of the notice of my authorization from MDCH, before beginning to submit Medicaid claims.
- This authorization shall remain in effect until I notify the MDCH in writing to the contrary or MDCH negates it.
- As a condition of receiving payment from Medicaid and programs for which the MDCH is the fiscal intermediary for services billed on my behalf, I certify and agree to all of the provider certification conditions above and on the **reverse side** of this document.

5. Provider's Name *(print)*	6. Provider's Phone Number ( )
7. Provider's Signature *(Facsimile signatures will NOT be accepted)*	8. Date

BILLING AGENT CERTIFICATION:

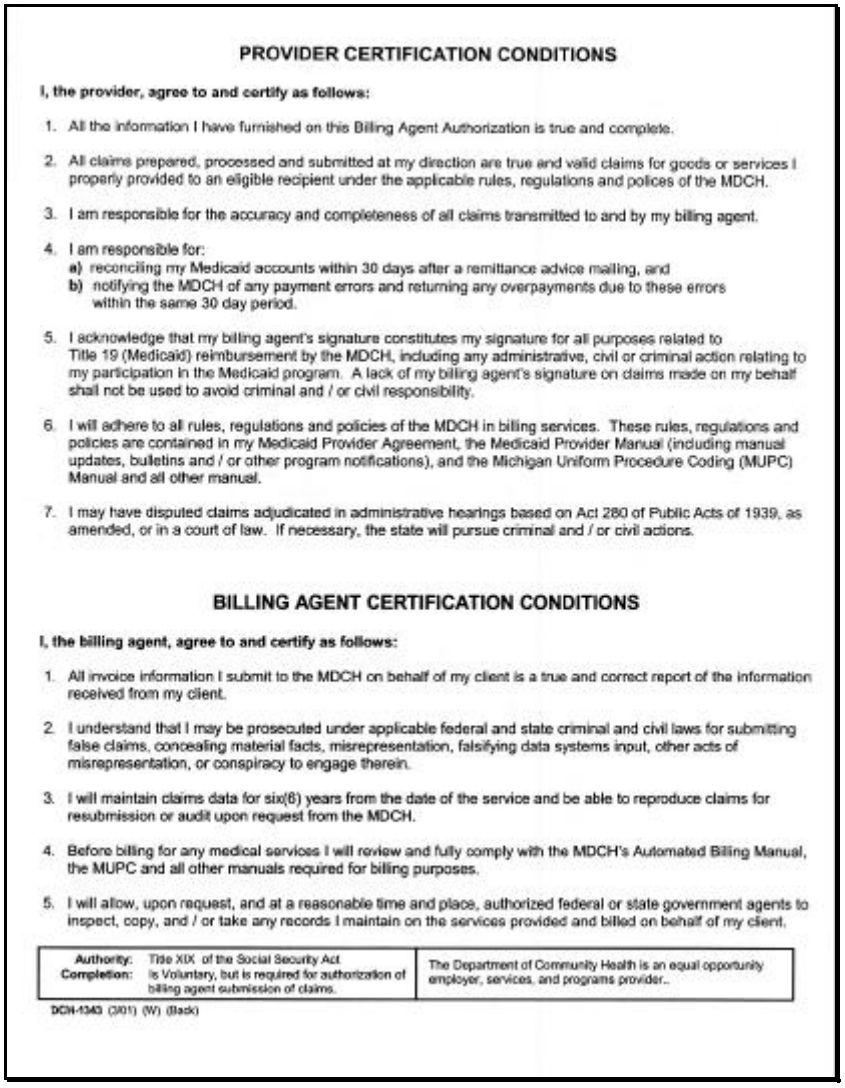
- I am a representative of the business authorized by MDCH to submit Medicaid claims via electronic media. My signature below signifies agreement to the billing agent certification conditions on the reverse side of this document.

9. Billing Agent Representative's Name and Title Name (print)	10. Billing Agent's Phone Number ( )
11. Billing Agent Representative's Signature *(Facsimile signatures will NOT be accepted)*	12. Date

RETURN TO: PROVIDER ENROLLMENT
MICHIGAN DEPARTMENT OF COMMUNITY HEALTH
PO BOX 30238
LANSING MI 48909

DCH-1343 (3/01) (W) Replaces and Obsoletes MSA-1343

Figure 2-2: Billing Agent Authorization Form (DCH-1343) for Providers to Submit to MDCH (Front)



PROVIDER CERTIFICATION CONDITIONS

I, the provider, agree to and certify as follows:

1. All the information I have furnished on this Billing Agent Authorization is true and complete.
2. All claims prepared, processed and submitted at my direction are true and valid claims for goods or services I properly provided to an eligible recipient under the applicable rules, regulations and polices of the MDCH.
3. I am responsible for the accuracy and completeness of all claims transmitted to and by my billing agent.
4. I am responsible for:
   a) reconciling my Medicaid accounts within 30 days after a remittance advice mailing, and
   b) notifying the MDCH of any payment errors and returning any overpayments due to these errors within the same 30 day period.
5. I acknowledge that my billing agent's signature constitutes my signature for all purposes related to Title 19 (Medicaid) reimbursement by the MDCH, including any administrative, civil or criminal action relating to my participation in the Medicaid program. A lack of my billing agent's signature on claims made on my behalf shall not be used to avoid criminal and / or civil responsibility.
6. I will adhere to all rules, regulations and policies of the MDCH in billing services. These rules, regulations and policies are contained in my Medicaid Provider Agreement, the Medicaid Provider Manual (including manual updates, bulletins and / or other program notifications), and the Michigan Uniform Procedure Coding (MUPC) Manual and all other manual.
7. I may have disputed claims adjudicated in administrative hearings based on Act 280 of Public Acts of 1939, as amended, or in a court of law. If necessary, the state will pursue criminal and / or civil actions.

BILLING AGENT CERTIFICATION CONDITIONS

I, the billing agent, agree to and certify as follows:

1. All invoice information I submit to the MDCH on behalf of my client is a true and correct report of the information received from my client.
2. I understand that I may be prosecuted under applicable federal and state criminal and civil laws for submitting false claims, concealing material facts, misrepresentation, falsifying data systems input, other acts of misrepresentation, or conspiracy to engage therein.
3. I will maintain claims data for six(6) years from the date of the service and be able to reproduce claims for resubmission or audit upon request from the MDCH.
4. Before billing for any medical services I will review and fully comply with the MDCH's Automated Billing Manual, the MUPC and all other manuals required for billing purposes.
5. I will allow, upon request, and at a reasonable time and place, authorized federal or state government agents to inspect, copy, and / or take any records I maintain on the services provided and billed on behalf of my client.

Authority: Title XIX of the Social Security Act **Completion:** is Voluntary, but is required for authorization of billing agent submission of claims.	The Department of Community Health is an equal opportunity employer, services, and programs provider..

DCH-1343 (3/01) (W) (Back)

Figure 2-3: Billing Agent Authorization Form (DCH-1343) for Providers to Submit to MDCH (Back)

2.4 COMPLETING THE AUTHORIZATION PROCESS

An **original** (no photocopies) DCH-1343 must be completed by the provider according to the instructions on the form. The pink copy should be retained by the provider, the billing agent should keep the yellow copy, and the original should be forwarded to:

Provider Enrollment Unit
MDCH
P.O. Box 30238
Lansing, MI 48909-7738

The provider will be notified in writing or by e-mail when the DCH-1343 has been processed. Billing Agents who wish to receive the notification directly should enclose a return envelope. The provider must then notify the billing agent to begin submitting claims on the provider's behalf. **Processing of the DCH-1343 takes approximately two weeks**. If the provider does not receive a response to the DCH-1343 within four weeks, a new form must be submitted. A provider's claims prepared by an unauthorized billing agent will be rejected with explanation code 013 ("The invoice was submitted by Electronic File without authorization from the provider"). Until the provider receives the authorization back from MDCH, claims must be submitted on paper.

2.5 REVOKING AUTHORIZATION

The authorization to bill on electronic file may be revoked at any time. The billing agency may reapply for participation and undergo another systems test. In the interim between the revocation and the new authorization, the billing agent may submit claims on paper only.

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3 TESTING

A billing agent must successfully complete the initial testing procedures before being authorized to submit claims. Each invoice type the billing agent wishes to submit must be tested as described in the following sections. These procedures can also be found at the MDCH Web site: Go to www.mdch.state.mi.us, then click “Medical Services Administration.”

3.1 ELECTRONIC TEST FILE SPECIFICATIONS

Prospective billing agents should complete internal systems testing to ensure that their billing systems are capable of producing electronic claim files containing properly prepared and edited claim data. The specifications for these files is found in Section 4 and the appendices.

Each billing agent must then prepare a test file to be submitted to the Automated Billing Unit. The Automated Billing Program Coordinator will assign parameters for a billing agent ID number for the electronic test file.

The **Billing Agent ID Number** is a four-digit alpha or numeric code used to identify all electronic file headers and trailers submitted and must be included in all records. The field should be right-justified and left-zero filled.

An electronic test file should consist of data from a minimum of 25 previously submitted or new claims. This test file must conform to the specifications outlined in Section 4.

NOTE: Claims contained on a test file will not be processed for actual payment; payment will be handled using paper forms until the billing agent is fully authorized.

3.2 INITIAL TEST EVALUATION

Systems tests are evaluated on the basis of four criteria. Failure of **any** of these criteria is considered a failure of the entire test.

1. **Format:** Claim data must be in ASCII format, with one record per block separated by a "Return" and "Line Feed." Records may be fixed or variable length, with the ending spaces dropped.

2. **Encoding:** Claim data is considered properly encoded if it can be interpreted correctly by the IP system.
3. **Record assembly (UB-92/EMC 5.0 only):** After the claim data has been encoded into the appropriate record format, these records must be properly assembled into invoice record sets and an appropriate Claim Reference Number assigned to each record set. Each file will begin with a **header record** and end with a **trailer record** containing the correct record count of the file.
4. **Claim Editing:** Claim data will be considered properly edited if the explanation codes reported by the IP system do not indicate conditions that must be edited. Significant volumes of any edit or failure to complete the claim as required by the MDCH will also cause the test to fail.

The billing agent will be notified of the test results approximately two weeks after the electronic test file is submitted. Reports generated by the test will be sent to the billing agent and problem areas will be defined.

Specific claim-oriented details of the systems test will be available if the test passes the first three criteria mentioned above. These details will be in the form of an electronic RA file. The electronic RA file may be used by the billing agent to test their system's capability to process the electronic RA file as well as to verify test result reporting.

3.3 RETESTING

If the billing agent failed any of the criteria, they may submit a new electronic test file after correcting the problems.

The billing agent may request no more than three retests per claim type in any three-month period.

The initial test and three retests in any one-year period are provided at no charge to the billing agent. Any additional retesting may require an additional charge per test.

4 PREPARING ELECTRONIC CLAIM FILES

Before any file can be submitted to the MDCH Invoice Processing System, whether for testing or actual payment, the file must be prepared. This section gives some background on that preparation as well as the file transfer system through which the file is submitted.

4.1 INTRODUCTION TO THE FILE TRANSFER SYSTEM

The File Transfer System provides a standardized method for MDCH to exchange files with an outside source (user).

This system is designed to:

- satisfy security measures.
- automate file transfers.
- allow for flexible hours and workload volumes.
- provide expanded communication protocol support.
- balance and verify files transferred to and from MDCH.
- provide audit trail of files transferred between MDCH and a user.

To maintain a highly secure environment, a communications gateway is being used to interface MDCH with users. All data files coming into and going out of MDCH are stored on the gateway computer. At scheduled times of the day, MDCH exchanges data between the gateway computer and the mainframe.

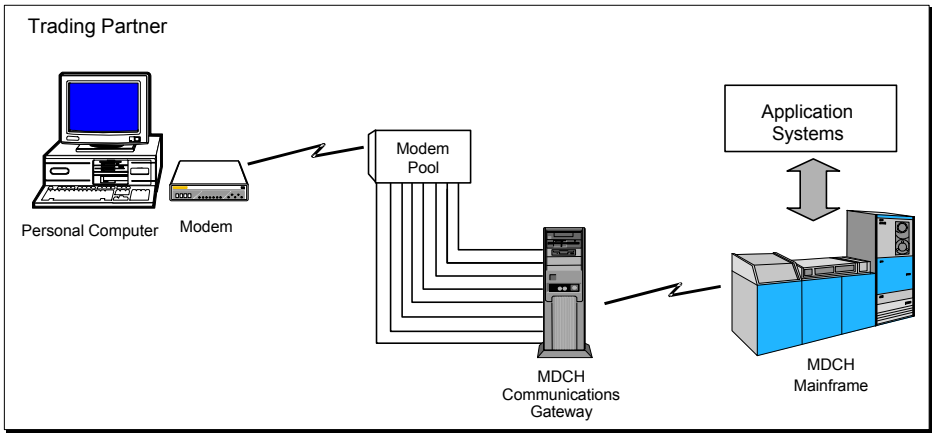

Figure 4-1: MDCH Communications Gateway

The telephone number for the gateway is **517-373-6181**. Software associated with the modem pool looks for the next available line if the first line is busy.

4.2 FILE REQUIREMENTS

Electronic files submitted to the MDCH through the Data Exchange Gateway must meet the following requirements.

The following requirements apply to all ANSI X12 837, UB-92/EMC 5.0, and MDCH proprietary claims:

a. The deadline for electronic file input to each weekly processing cycle is Wednesday at 5:00 p.m., except as may be affected by holidays.

b. Billing agents who notify the Automated Billing Program Coordinator by e-mail may choose not to receive the electronic Remittance Advice file.

c. No compression or Internet file transfer is allowed at this time. All electronic files must be submitted as ASCII data, with one record per block separated by a carriage return and line feed.

The following requirements apply only to UB-92/EMC 5.0 and MDCH proprietary claims:

d. Each electronic file must contain at least one complete batch. There is no maximum number of batches that may be submitted on any one electronic file. There is no maximum number of claims that can be submitted.

e. All batches in an electronic file must be complete and unique to that file; that is, a batch cannot appear in two electronic files.

f. File Transfer Control records are required at the front and back of every file being transferred with MDCH. These control records validate users and files. Specifications for these control records are discussed in Section 4.2.1 and shown in Table 4-1.

4.2.1 Electronic File Preparation for the UB-92/EMC 5.0 and Proprietary Claims

Specific control records are required for the File Transfer System.

- Each electronic file must **start** with an MDCH header record containing the billing agent identification number.
- Each electronic file must **end** with an MDCH trailer record containing the billing agent identification number and the record count of the file, including the header and trailer records.

Billing agents can use the MDCH TR9000 personal computer (PC) program or they can code the control records themselves. The TR9000 program can be obtained by e-mail from:

AutomatedBilling@michigan.gov

Specific application data record layouts may not be included in this guide. They can be requested from the e-mail address above.

File Transfer Control records are required for proper balancing and validity edits. A control record is found at the beginning and end of each file that is being transferred to MDCH. Users sending a file to MDCH must provide the control records with individual data specifics defined by MDCH. Please contact the MDCH application analyst liaison for these specifics. MDCH will also apply the control records to files going out to users, with predefined data specifics.

The first four characters in a control record are "HDDR." The last control record is identical to the first control record except the first four characters are "TRLR" and a field is added for the TOTAL FILE RECORDS.

The data elements in the control records answer the following questions:

- Who sent the file?
- Which file is it?
- Does the internal ID match filename where it was transferred? Or is there a typo in file?
- Which MDCH application is waiting for the input file or created the output file?
- What day was the file created?
- Is the file intact? That is, did a line drop and are records missing?

Table 4-1. File Transfer Control Record Layout

Field	Data Element Name	Char	Description
1	Header-Trailer Control Record Identification	4	The value "HDDR" will be in the first control record to a file. The value "TRLR" will be in the last control record to a file.
2	Application Code *	2	Two-character program series identifying an MDCH application.
3	User Identification *	8	Unique assigned alpha numeric identification.
4	File Create Date	8	Format of CCYYMMDD for the date the file was created.
5	Batch Number *	12	Information defined by the MDCH systems analyst.
6	File Identification *	8	Alphanumeric field identifying the file. The first four characters are compared against the filename location selected off the menu when transferring the file to MDCH. The last four characters are determined by the MDCH systems analyst.
7	Total File Records	6	This field is spaces in the HDDR control record. The TRLR control record holds a numeric value to the physical number of records in the file, including the HDDR and TRLR records.

**The values for these fields are defined by the MDCH applications analyst and can be requested at AutomatedBilling@michigan.gov.*

4.2.2 Sending UB-92/EMC 5.0 and Proprietary Claim Files to MDCH

Each file that is sent to MDCH must have only two control records: one at the front and one at the back of the file. More

than one file with the same name can be sent on the same day; each will be listed individually.

4.2.3 Sending ANSI X12 837 Claim Files to MDCH

All ANSI X12 records have header and trailer files built into them so those files do not have to be added.

4.2.4 Receiving Files from MDCH

When billing agents receive a file from MDCH, such as a 997 Acknowledgment, each file will be listed by its filename, size in bytes, and date loaded to the user's mailbox. Once a file is downloaded, it will disappear from the user's view. To download that file again, the user must call the Information Line at 1-800-292-2550 to have the file retrieved.

4.2.5 File Back-Up

Billing agents should copy transferred files immediately as a back up for their site.

It is the agent's responsibility to retain back-up files until the party at the final destination has verified and backed up the files. Should the file not be received in its entirety, it may have to be resent using the back up. MDCH retains back-up files sent to users; likewise, users should retain back ups of the files sent to MDCH.

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5 USING THE DATA EXCHANGE GATEWAY (DEG)

The State of Michigan has established a point-to-point protocol (PPP) communications connection for the DEG. This connection is independent of the platform used to transmit data, whether it is from a Unix, Apple, mainframe, or Windows-based personal computer. The PPP server is a T1 connection divided into twenty-four 56 kbps (kilobytes per second) connections. Since this is a digital connection at the DEG, downloads of 56 kbps and faster, using compression, will be possible.

5.1 HARDWARE, SOFTWARE, AND CONNECTION REQUIREMENTS

Transmitting Computer: Any

Modem: Up to 56 kilobytes per second

Software: **Both** PPP Dialup and FTP (File Transfer Protocol) required once a connection is made into the DEG. (Windows 95 and NT both have PPP and FTP software built in.)

PPP phone number: 517-373-6181

TCP/IP address: 204.23.253.97

5.2 GETTING STARTED WITH POINT-TO-POINT PROTOCOL

The following instructions are provided as an example of how to establish a connection using Microsoft Windows software on a personal computer (PC). Since PPP does not depend on a particular platform or software, all of the possible methods of connecting cannot be addressed here. If there are questions about the computer a file is being sent from, contact the local systems administrator.

1. Double-click the My Computer icon on the computer desktop. The icons available on this computer will be shown (Figure 5-1).

Figure 5-1: Selecting the Dial-Up Networking Icon

2. Double-click the Dial-Up Networking icon in the My Computer configuration window. The Dial-Up Networking option will show (Figure 5-2).

Figure 5-2: Dial-Up Networking Options

3. Double-click the Make a New Connection icon. The Make New Connection window appears (Figure 5-3).
4. Enter **MDCH** and select a modem or accept Standard Modem. Click **Next**.

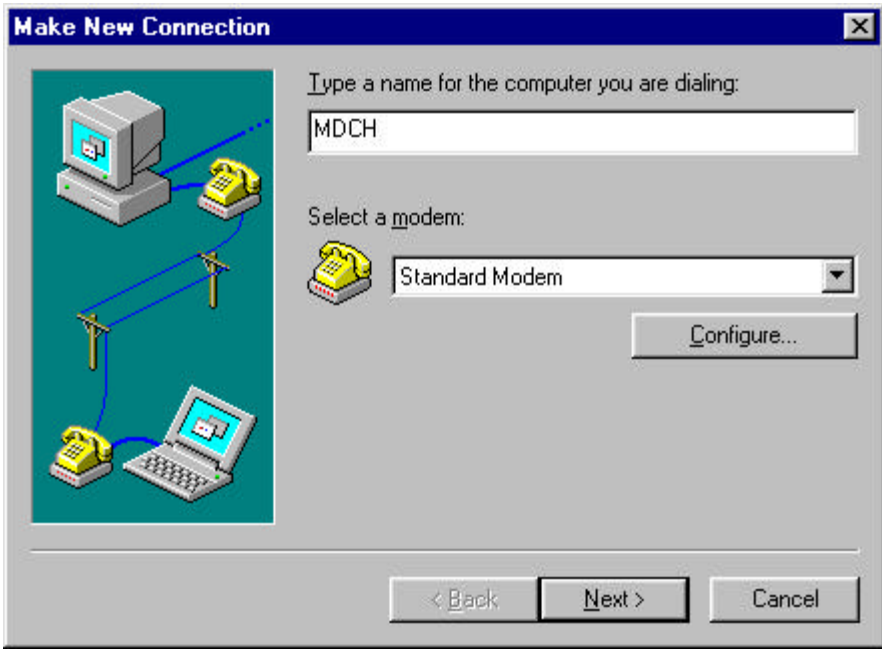

Figure 5-3: Naming the Modem Connection

5. In the Make a New Connection window, enter the area code **517** and telephone number (**373-6181**) in the appropriate fields, then enter **United States of America (1)** as the country code (Figure 5-4). Click Next.

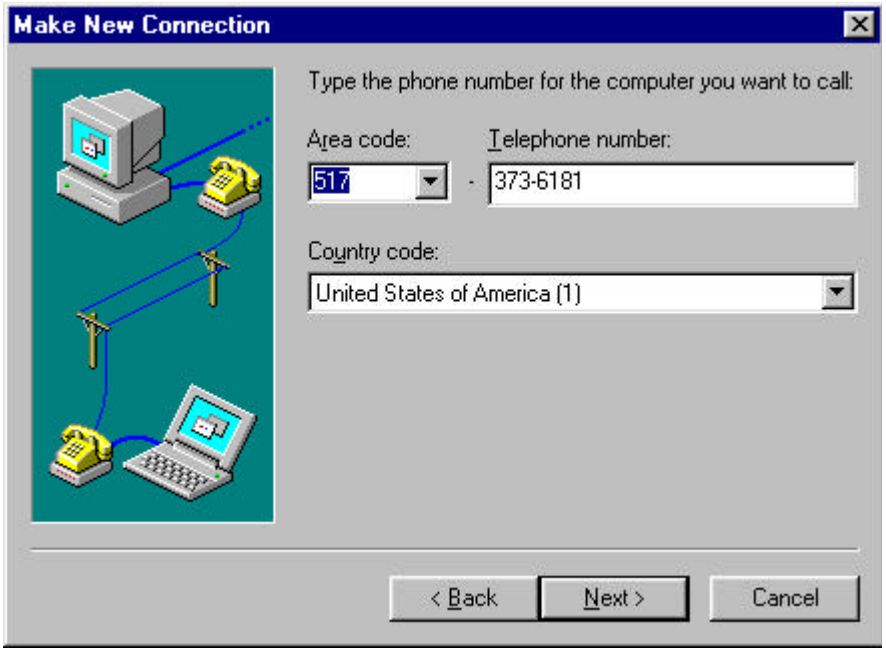

Figure 5-4: Specifying the Modem Connection

6. Click Finish. A new connection is established (Figure 5-5). The Make New Connection window automatically closes, and the connection icon appears in the My Computers window.

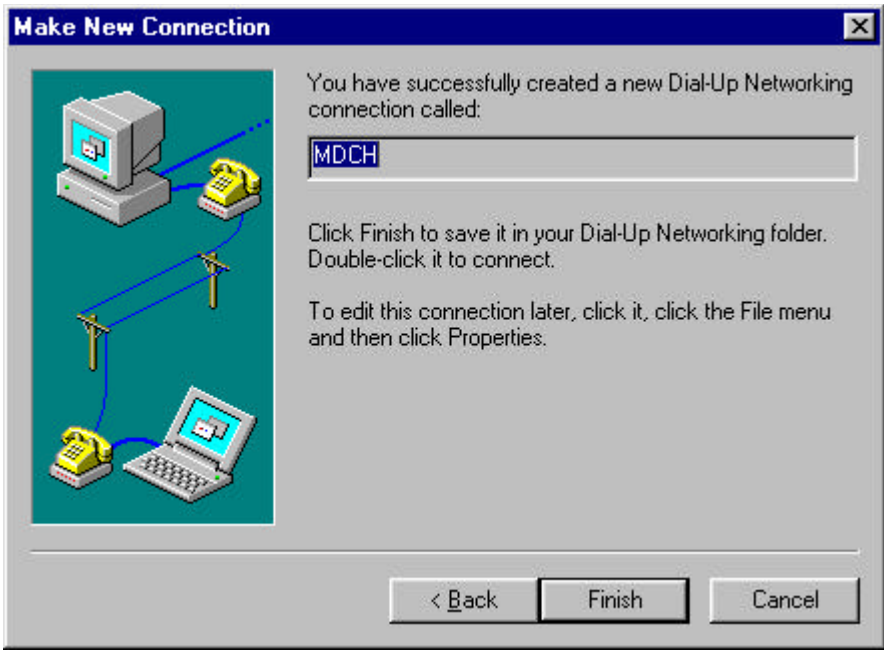

Figure 5-5: New Dial-Up Connection Confirmation Window

7. Return to the Dial-Up Networking window.
8. Select the MDCH icon just created by clicking on it once to select it.
9. Click File from the menu bar, then select Properties from the drop-down list. The window in Figure 5-6 appears.

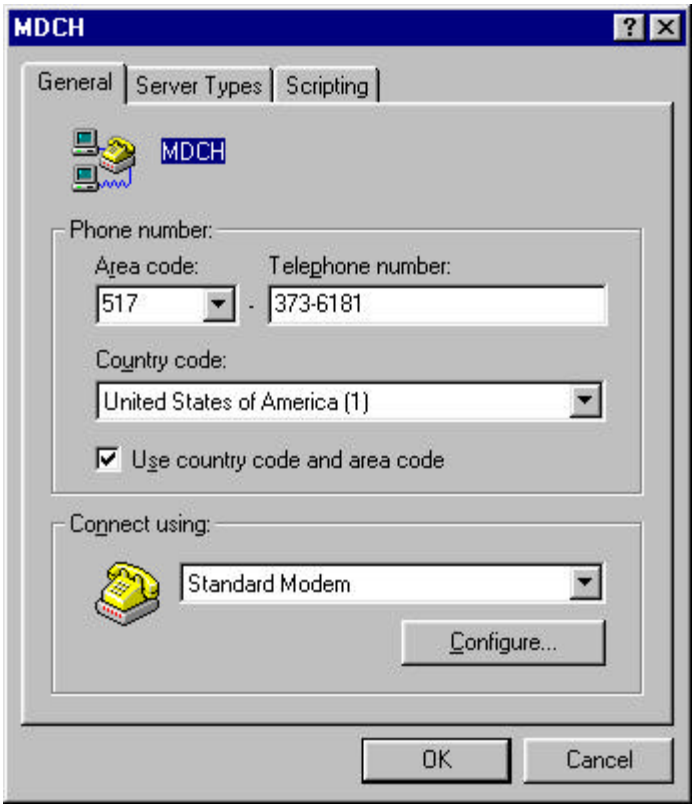

Figure 5-6: Verifying Dial-Up Connection Settings

10. Verify that the information is correct, then click the Server Type tab. The window in Figure 5-7 will appear.

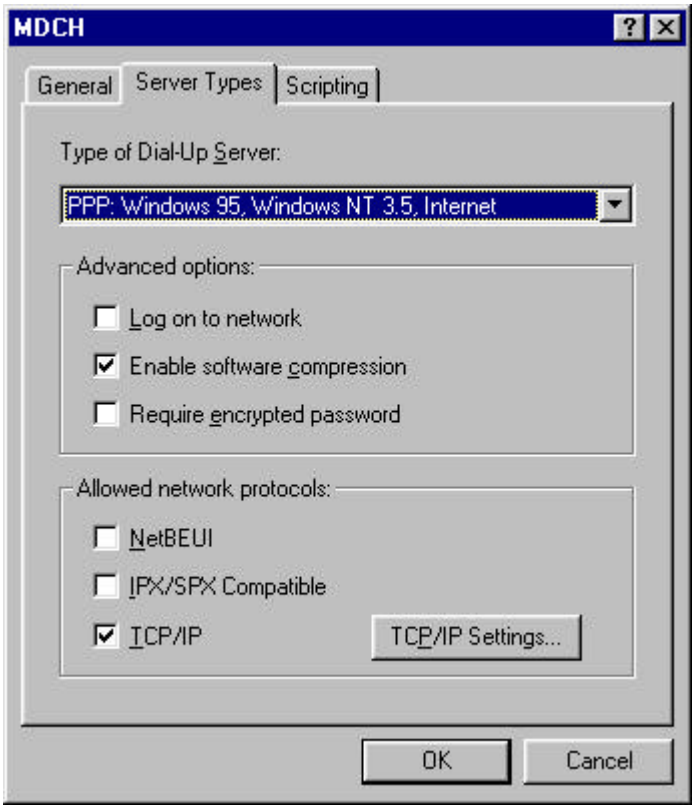

Figure 5-7: Server Types Window

11. Select the Type of Dial-Up Server shown, check the box next to Enable software compression by clicking in it once, and check TCP/IP box, then click the TCP/IP settings button. The window in Figure 5-8 appears.

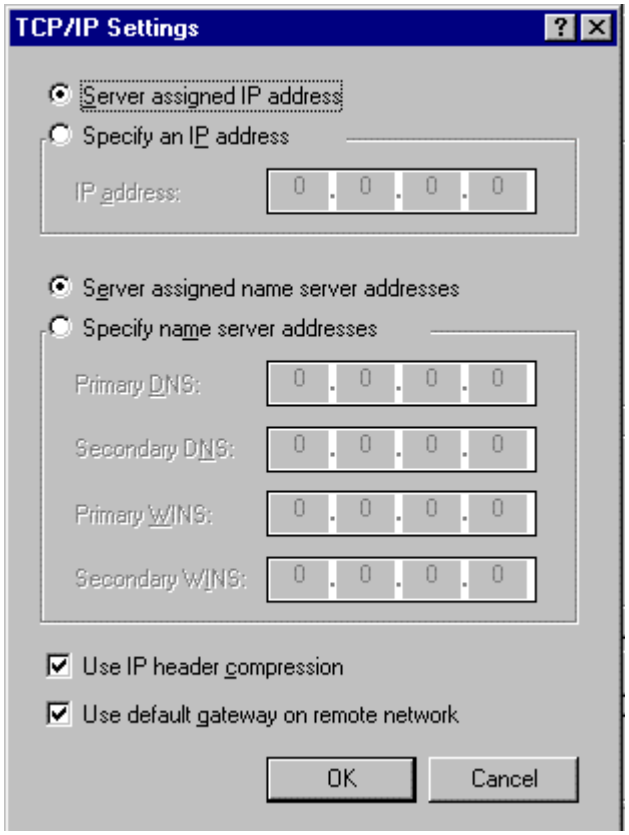

Figure 5-8: TCP/IP Settings Window

12. Modify the window on the computer to look like the window in Figure 5-8, then click **OK**. Click **OK** again to close the MDCH window. The PPP software is ready.
13. To log on to the PPP process, go to the Start menu, and select Programs, Accessories, and Dial-Up Networking.
14. Double-click the MDCH icon.
15. The Connect To window appears (Figure 5-9).

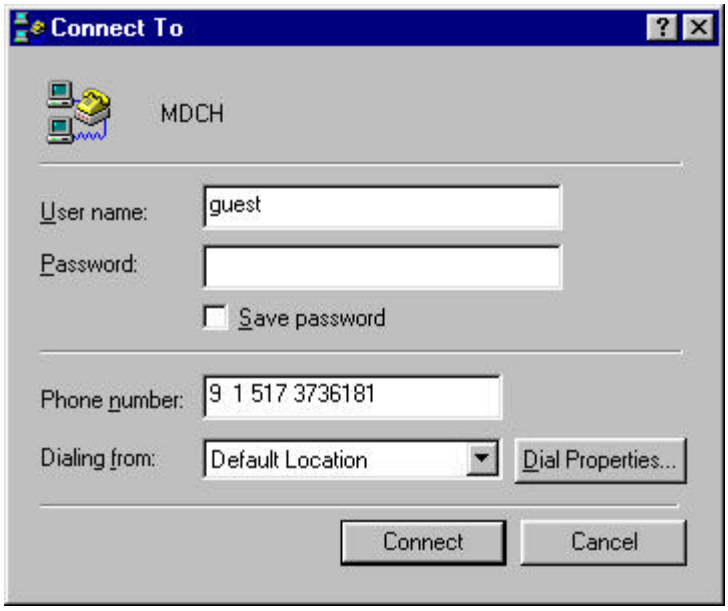

Figure 5-9: Connecting to the MDCH Gateway

16. Enter the Userid and password **guest**. (This Userid and password will establish that a connection has been made. Other Userids and passwords are used for testing and production.)
17. Verify that the correct telephone number appears in the correct field.
18. Click Connect.
19. Once the connection is established (the sounds of the dialing an connection will be heard), the PPP window minimizes itself.
20. Close the Dial-Up Networking window.

5.3 STARTING THE FILE TRANSFER PROTOCOL (FTP) SESSION IN THE TEST ENVIRONMENT

The following example is based on the software that comes with Windows 95 or NT. It is similar to the DOS commands used by other operating systems. Other Windows-based FTP software is available. **NOTE**: When using graphical user interface (GUI) FTP software, the options will need to be set to prompt for a remote destination when "putting" a file to the DEG. The DEG is very specific to the syntax described in the "put" command below.

1. To start an FTP session, click the **Start** button in the lower left corner of the computer screen.
2. Click Run from the Start menu.

3. Enter **ftp 204.23.253.97** in the open field, then click **OK**.
4. Once the FTP software starts, a DOS window appears, and the DEG asks for a Userid. Enter **dchtst5** or **dchtst6** and press the Enter key.
5. When prompted for a password, enter the Userid you selected in the previous step and press Enter.
6. Once the DEG responds, select an action from Table 5-1.

Table 5-1. FTP Commands for the DEG

Command	Description	Example
dir	Show directory of files waiting	
put	Move a file to the DEG	put c:\4275t 4275t@dchedi (for ANSI X12 837 v 4010 and 3051 files) or c:\4275t 4275t@dchbull (for UB-92 files). The "t" at the end of the file name indicates this is a test file.
get	Move a file from the DEG	get 4276t c:\4276t
user	Change Userid	user dchtst6 dchtst5
del	Delete a file	del 4276t (Deletes all files of this number!)
quit	End the FTP session	
help	Shows a list of commands	
bye	Ends session	

7. To end the FTP session, type **bye**.
8. To end the PPP session, click the minimized Dial-Up Networking icon at the bottom of the screen. Click Disconnect.

File Naming Standards: Any file name that ends with a "t" will not be delivered to the production environment. A "t" designates a testing file. When a test file is needed, the Information Line at 1-800-292-2550 to let them know the test file is ready to be picked up.

5.4 USING PPP AND FTP IN THE PRODUCTION ENVIRONMENT

When connecting to the DEG, use the Userid and password **guest** for the PPP connection. Use the Userid and password (e.g., DCH00XX, where XX represents your billing agent ID assigned by MDCH).

Once the logon is accepted and the prompt **ftp>** appears (as shown in Figure 5-10), type **dir** to select the directory of files available.

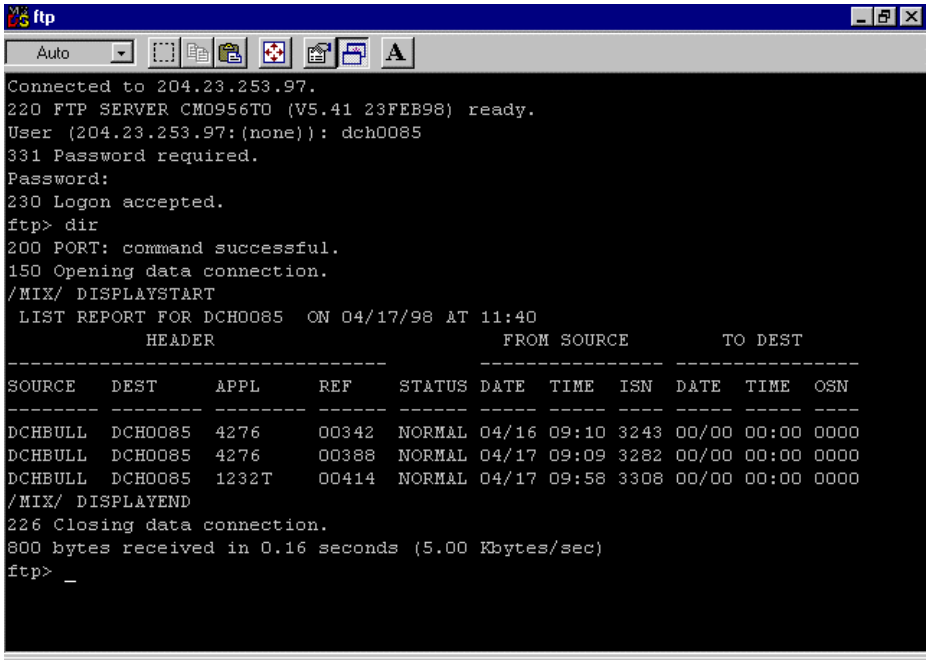

Figure 5-10: FTP Window in a Production Environment

5.4.1 "Putting" a File on the DEG

When you send an Invoice Processing or Managed Care file to the DEG, take the following steps.

1. Type **put <volume>\<directory>\<file> <space> <file number>@<location>**. For example, **putc:\dos\4780 4780@dchedi**, where **c** is the hard drive, **DOS** is the directory, **4780** is the file for the primary care physician, followed by a **space**, the **@** sign, and a location of **dchedi (dch** indicates the Department of Community Health, and **edi** indicates the American National Standards Institute X12 837 transaction format).
2. Once the file is transferred to **dchedi**, translation begins immediately and a 997 Acknowledgment transaction is produced and moved to the sender's mailbox.
3. Enter the **dir** command to see the 997 with the name of the file sent.
4. Download the 997 file by entering a get command, being careful to use a different file name for the destination system so the file sent is

not written over. Adding an "a" to the file name would indicate it has been acknowledged.

5.4.2 "Getting" a File from the DEG

1. From the window shown in Figure 5-10, type **dir** in response to the ftp> prompt.
2. From the list of files shown, look at the column labeled **APPL**. These are files ready to be retrieved.
3. Type, in this example, **get 4276 c:\download\4276**. This will move the ***oldest*** 4276 file to the sender's PC. The file will be downloaded to the C drive, in the "download" directory, to file 4276.

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6 FILES EXCHANGED

The File Transfer System provides a standardized way for MDCH to exchange files with outside sources (users, billing agents) eligible to bill MDCH for health care services. There are two types of files exchanged in claims transactions: (1) files billing agents send to MDCH and (2) files MDCH sends to billing agents. Billing agents submit three major types of claims: professional, institutional, and dental. Each of these types of claims has at least one valid electronic format. MDCH sends two types of files to billing agents: an acknowledgment for the receipt of a submission and remittance advice regarding each individual claim.

NOTE: The Michigan Department of Community Health is actively working toward implementing the federally mandated Health Insurance Portability and Accountability Act (HIPAA) transaction standards. Once the HIPAA standards go into effect, MDCH will only accept HIPAA-compliant transactions. Complete implementation guides for all HIPAA transactions can be obtained through the Washington Publishing Company at www.wpc-edi.com.

6.1 FILES BILLING AGENTS SEND TO MDCH

6.1.1 Professional Claims

Specifications for both versions 3051 and 4010 of the ANSI X12 837 Professional claim transaction set are found on the MDCH Web site at www.mdch.state.mi.us (then click “Medical Services Administration”).

The specifications for the “envelope” for this transaction are included in this document in Appendix B2.

6.1.2 Institutional Claims

Specifications for the electronic UB-92/EMC 5.0 claim transaction are found on the MDCH Web site. Specifications for the electronic “envelope” are found in Appendix B1.

The electronic “envelope” for the ANSI X12 837 Institutional claim, version 4010, is found in Appendix B2. It is identical to the envelope for the Professional claim **except for** the values found in element GS08.

6.1.3 Dental Claims

Specifications for the MDCH proprietary dental claim transaction are posted on the MDCH Web site as part of a document called "Specifications for the Dental Claim Transaction." Specifications for the envelope are available from Automated Billing and are similar to the "envelope" header and trailer found in Appendix B1.

6.1.4 Long Term Care Claims

Specifications for the MDCH proprietary long term care claim and envelope are available from AutomatedBilling@michigan.gov.

6.2 FILES MDCH SENDS TO BILLING AGENTS

6.2.1 997 Acknowledgment

A sample 997 Acknowledgment and specifications for the 997 Acknowledgment for both versions 3051 and 4010 are found in Appendix C of this document.

6.2.2 Remittance Advice

Specifications for the ANSI X12 835 and MDCH proprietary remittance advice are found in Appendix C of this document. (**NOTE**: The ANSI X12 835 remittance advice is under development.)

7 RESOURCES FOR ELECTRONIC BILLING

7.1 TECHNICAL SUPPORT

The MDCH will provide limited technical assistance to providers and their authorized billing agents in the design and implementation of an electronic billing system for the preparation of Medicaid, CSHCS, and SMP claims.

This assistance may be provided by:

- **Inquiries regarding policies and procedures** (e.g., Medicaid coverages and pended claims) must be directed to the toll-free information line at 1-800-292-2550.
- **Review of documentation** – Review by the Automated Billing Program Unit of any proposed systems documentation will be completed as staffing and time allow, or
- **In-house consultation** – Requests for an in-house consultation on the design and implementation of an electronic billing system will be evaluated individually.

7.2 PROVIDER POLICY MANUALS

Billing agents are urged to obtain the policy manuals applicable to the specific provider types for whom they submit claims. These manuals indicates the policies and procedures used by the MDCH, including a general description, coverages and limitations, and billing and inquiry.

Policy manuals are available at a nominal cost from MSA Forms Distribution, MDCH, P.O. Box 30479, Lansing, Michigan 48909-7979.

Provider manuals are available for the following:

Ambulance
Chiropractor
Community Mental Health Services Board
Dental
Family Planning Clinics
Federally Qualified Health Centers/Tribal Health Centers
Hearing Aid Dealers
Hearing and Speech Centers
Home Health Care
Hospice
Hospital
Laboratory
Long-Term Care
Maternal and Infant Support Services
Medical Suppliers/Durable Medical Equipment
Medicaid Health Plans
Pharmacy
Practitioner (e.g., physicians, advanced practice nurses, podiatrists, and medical clinics)
School Based Services
Rural Health Clinics
Vision

7.3 ADDITIONAL RESOURCES

The following materials may be obtained from the MDCH in addition to specific claim-type electronic file formats:

- **Bulletins** – Items of information and policy affecting the administration of the Medicaid Program are conveyed through the Medical Assistance Program Bulletin series. Bulletins also communicate procedural changes and transmit revisions to a manual. It is important to keep the manual up to date. Bulletins that do not have accompanying revised manual pages should be kept until the information is incorporated in the manual.

Bulletins are numbered in sequence for each provider manual noted in the Bulletin Header. Bulletins affecting multiple provider types will have another number assigned in the lower left corner.

Bulletins are automatically mailed to subscribers of the affected provider manuals. They are also available at www.mdch.state.mi.us under "Medical Services Administration."

- **Numbered Letters –** General program information or announcements are transmitted to providers via numbered letters. These letters should be kept for reference.
- **Remittance Advice Messages** – Remittance Advice (RA) messages are used to transmit special billing information on specific problems. The messages are numbered consecutively and followed by the year (e.g., 12-85 is the twelfth bulletin issued in 1985). RA messages are mailed to specific provider types with the Remittance Advices; therefore, the RA messages to any one provider type may not be numbered consecutively.

  RA messages are sent with paper Remittance Advices.

The Michigan Uniform Billing Manual contains information about the UB-92 paper claim form. It will be needed by providers who submit institutional claims electronically. The Michigan Uniform Billing Manual is based on the National Uniform Billing Manual but is enhanced to include Michigan-specific billing information. In Michigan, the UB-92 is currently the accepted claim form for Medicare, Blue Cross, TRICARE/CHAMPVA, Worker's Compensation, Medicaid inpatient and outpatient claims and all commercial insurer and HMO claims.

Subscriptions can be purchased by contacting:

State Uniform Billing Committee
Michigan Health & Hospital Association
Attention: UB-92 Manual Subscription
6215 W. St. Joseph Highway
Lansing, Michigan 48917-4852
(517) 323-3443

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GLOSSARY

ANSI X12 837	The X12 standard health care claim or encounter EDI transaction, used for institutional, professional, and dental claims.
ASCII	American Standard Code for Information Interchange
Automated billing agent	Another term for an electronic billing agent.
Billing agent	An organization that is authorized to submit claims for payment on behalf of provider; the billing agent may be the provider itself.
Bulletin	Items and information and policy affecting the administration of the Medicaid Program; conveyed through the Medical Assistance Program Bulletin series.
CMS	Centers for Medicaid and Medicare Services; formerly the Health Care Financing Administration (HCFA)
CPT	Current Procedural Terminology. Codes used by providers to describe services rendered.
CSHCS	Children's Special Health Care Services
E-billing agent	See "electronic billing agent."
Electronic billing agent	An individual or agency who submits claims electronically. Also known as an "automated billing agent" or and "e-biller."
EMC 5.0	Electronic Media Claim version 5.0; also known as the electronic UB-92 claim. It is the electronic version of the paper UB-92 claim form.
HCFA	Health Care Financing Administration; now known as the Center for Medicare and Medicaid Services (CMS)
HCFA 1450	See "UB-92."
HCFA 1500	The Health Care Financing Administration's paper claim form for professional services.
HCPCS	Health Care Procedure Coding System
ICD-9-CM	International Classification of Diseases, Ninth Edition, Clinical Modification
ID	Identifier
IP	Invoice processing
MDCH	Michigan Department of Community Health
MSA	Medical Services Administration
Provider	An individual or organization that provides medical services.
RA	Remittance advice

Service Bureau	An organization that submits bills on behalf of a provider; also, a billing agent.
SHP	Special Health Plan for Children
SMP	State Medical Program
TR9000	An MDCH-provided software program that writes the required control records for MDCH proprietary and UB-92 files.
UB-92	Uniform Billing Form 92, also known as the "HCFA1450" paper form. The electronic version is the Electronic Media Claim (EMC) version 5.0. This form is used for Institutional claims.

A. TR9000 FILE PREPARATION PROGRAM INSTRUCTIONS

INTRODUCTION

The TR9000 file preparation program is available on a floppy disk at no cost to PC users who request it from AutomatedBilling@michigan.gov. This program builds the **required** File Transfer Control records at the front and back of MDCH proprietary and UB-92 files before the files are sent to the MDCH. Interactive screens let users enter variable fields. MDCH does not require the use of this program. It is provided for those who do not wish to program the logic to write the required control records.

Instructions for using the TR9000 accompany the software. They are found in the file tr9000.doc and are paraphrased in this section.

NOTE: The program requires as much work space on a PC as the size of the data file. TR9000 writes back to the original path name with the control records and automatically deletes the work area.

HOW THE TR9000 WORKS

A Selection List (TR9000.FIL) is built and maintained using information from the header and trailer records previously created through this program (TR9000). This reduces redundant keying and sets default values for files that are run through this program more than once.

TR9000 will prompt for information needed in the header and trailer records. Any of the default values may be replaced by the user. A temporary file (TR9000.WRK) is written with the new file, including the header and trailer records. At the end of the process the temporary file is written to the input pathname and the temporary file is deleted.

FUNCTIONS OF THE TR9000

The TR9000 can be used for the following purposes:

- To add an entry to the Selection List, and
- To delete an existing entry from the Selection List.

In addition, the TR9000 is run to add header and trailer records to a file after you have:

- Added data to an existing file or
- Created a new file.

INSTALLING THE TR9000

1. Change directory to where your data files are stored; for example, **C:\cd\<directory>**.
2. Insert floppy disk into the computer's floppy drive (usually A or B).
3. Type: COPY <floppy drive>.*.*
4. Copy files the following files to the hard drive:
   TR9000.DOC (this documentation)
   TR9000.EXE
   TR90DOC.BAT
5. Remove floppy disk; the TR9000 is ready to run.

RUNNING THE TR9000

Once the TR9000 is installed on the PC's hard drive, a window similar to that shown in Figure A1 will appear.

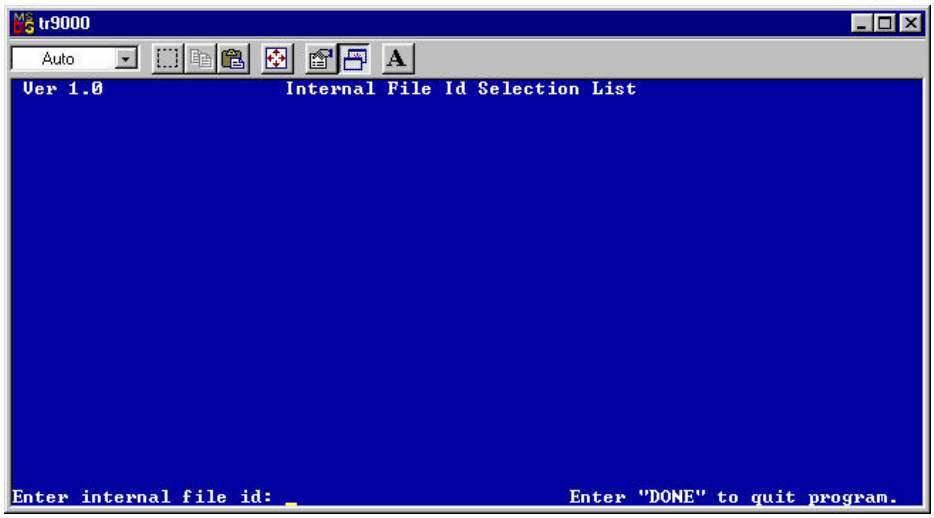

Figure A1: Sample Initial TR9000 Window.

1. To start the TR9000, in Windows Explorer, double-click the tr9000.exe icon.
2. Enter the eight-character alphanumeric Internal File ID assigned by MDCH. This ID will track many files or variants of the same file (e.g., 3602PMO1, 3602PTU1, 3713PWE1). **NOTE**: Type "DONE" at any time to quit the program.

3. Enter one of the following combinations at the beginning of the file name:

   3602 for an UB-92 (EMC 5.0) file, or

   3713 for a proprietary dental claim.

4. Once the Internal File ID has been entered, the following message appears at the bottom of the screen:

5. **Delete, Continue, or Restart < D/C/R >**
   NOTE: **Do not use the Enter key** after each entry; use either the down arrow or the Tab key. Once all the fields have been completed, press the Enter key.

   a. Pressing **D** will delete an entry from the Selection List, but it will **not** delete the file from your disk.

   b. Pressing **C** brings up the next screen where more detail can be entered about a selected file. (See Figure A2.)

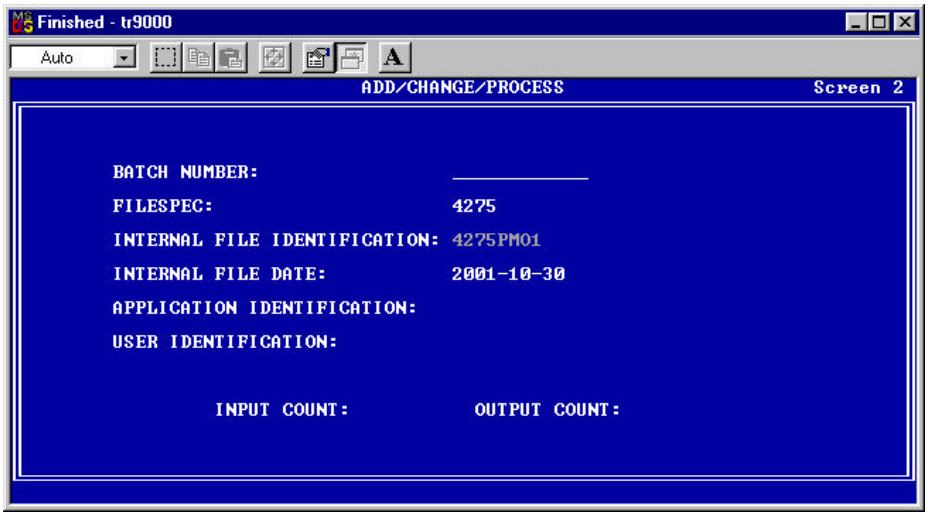

Figure A2: TR9000 Add/Change/Process Screen

   c. Pressing R indicates an error in the selection and the ID number must be reentered correctly.

The fields on the Add/Change/Process screen have the following meanings:

Batch Number: A 12-character date-and-time field defined in the application as CCYYMMDDHHMM.

Filespec: A 36-character field used to name the file. For example, if there is a data file named 4275 stored in a directory called GLWIN, the pathname would be C:\GLWIN\4275.

Internal File Identification: An unmodifiable 8-character field carried forward from Screen 1 to Screen 2.

Internal File Date: A field filled automatically with the current date that can be changed.

Application Identification: A 2-character field defined as **MA** (for Medicaid Application), used by other application programs.

User Identification: An 8-character (seven characters and a space) field assigned by MDCH to authorized users. This currently is DCH00XX, where XX is the Billing Agent ID of the provider.

Input Count and **Output Count** are provided by the program. The Input Count is the number of records entered, and the Output Count is the same, plus two control records.

Bypass Count: A count of invalid (blank) records or preexisting header and trailer records in a file. "File Contains No Data Records" appears below the Output Count if a file contains only a header and trailer record; such a file would be rejected by the transfer system

The remainder of the program is self-explanatory. Questions about the TR9000 program should be directed to an MDCH File Transfer System analyst at AutomatedBilling@michigan.gov.

CONTENTS

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B1 MDCH PROPRIETARY "ENVELOPES"

All billing agents who submit claims electronically must append header and trailer records to their submissions. These electronic “wrappers” or “envelopes” alert the system of the beginning and ending of a submission.

B1.1 Institutional Proprietary Header Record

The following Proprietary Header Record is required on all UB-92/EMC v5.0 institutional claims submitted to MDCH. Proprietary remittance files sent from MDCH to billing agents contain a similar header.

Specifications for the headers of the proprietary Dental and Long Term Care claim transactions can be obtained from AutomatedBilling@michigan.gov. These specifications are similar to the institutional specifications.

D.E. #	DATA FIELD NAME	PICTURE	USAGE	FROM	THRU
05	EDI – HEADER – RECORD				
	10 EDI – TYPE VALUE "HDDR"	X(4)	4	01	04
	10 EDI – APP VALUE "MA"	X(2)	2	05	06
	10 EDI – USER VALUE "MMISXXXX"	X(8)	8	07	14
	OR "DCHXXXX "				
	WHERE XXXX = CLAIM ID				
	10 EDI – DATE – CYMD (CREATION DATE)	X(8)	8	15	22
	10 EDI – TRANSFER – DATE (OR USE CREATION DATE)				
	15 TRANSFER – YYYY	X(4)	4	23	26
	15 TRANSFER – MM	X(2)	2	27	28
	15 TRANSFER – DD	X(2)	2	29	30
	15 TRANSFER – HH	X(2)	2	31	32
	15 TRANSFER – MINUTE	X(2)	2	33	34
	10 EDI – FILE				
	15 EDI-FILE-BEG VALUE "XXXX"	X(4)	4	35	38
	WHERE "XXXX" = 1232 DCH FILE NUMBER				
	WHERE "XXXX" = 3602 UB92 FILE NUMBER				
	WHERE "XXXX" = 3713 Non-UB92 FILE NUMBER				
	15 EDI-RUN-TYPE	X(1)	1	39	39
	88 PRODUCTION-RUN VALUE "P"				
	88 TEST-RUN VALUE "T"				
	15 EDI-BATCH	9(3)	3	40	42
05	FILLER = 1232	X(318)	318	43	360
05	FILLER = 3602	X(150)	150	43	192
05	FILLER = 3713	X(278)	278	43	320

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B1.2 Institutional Proprietary Trailer Record

The following proprietary trailer record is required on all UB-92/EMC v5.0 institutional claims submitted to MDCH. Proprietary remittance files sent from MDCH to billing agents contain a similar trailer.

Specifications for the trailers of the proprietary Dental and Long Term Care claim transactions can be obtained from AutomatedBilling@michigan.gov. These specifications are similar to the institutional specifications.

D.E. #	DATA FIELD NAME	PICTURE	USAGE	FROM	THRU
05	EDI – HEADER – RECORD				
	10 EDI – TYPE VALUE "TRLR"	X(4)	4	01	04
	10 EDI – APP VALUE "MA"	X(2)	2	05	06
	10 EDI – USERS VALUE IS "MMISXXXX"	X(8)	8	07	14
	OR VALUE "DCHXXXX "				
	WHERE XXXX = CLAIM ID				
	10 EDI – DATE – CYMD (CREATION DATE)	X(8)	8	15	22
	10 EDI – TRANSFER – DATE (OR USE CREATION DATE)				
	15 TRANSFER – YYYY	X(4)	4	23	26
	15 TRANSFER – MM	X(2)	2	27	28
	15 TRANSFER – DD	X(2)	2	29	30
	15 TRANSFER – HH	X(2)	2	31	32
	15 TRANSFER – MINUTE	X(2)	2	33	34
	10 EDI – FILE				
	15 EDI-FILE-NUMBER VALUE "XXXX"	X(4)	4	35	38
	OR WHERE "XXXX" = 1232 DCH FILE NUMBER				
	OR WHERE "XXXX" = 3602 UB92 FILE NUMBER				
	OR WHERE "XXXX" = 3713 Non-UB92 FILE NUMBER				
	15 EDI-RUN-TYPE	X(1)	1	39	39
	88 PRODUCTION-RUN VALUE "P"				
	88 TEST-RUN VALUE "T"				
	15 EDI-BATCH NUMBER	X(3)	3	40	42
	10 EDI – RECORD – COUNT	9(6)	6	43	48
	(RECORD COUNT INCLUDES "HDDR" & "TRLR")				
05	FILLER = 1232	X(312)	312	49	360
05	FILLER = 3602	X(144)	144	49	192
05	FILLER = 3713	X(272)	272	49	320

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B1.3 Modulus Eleven Check-Digit Routine

MDCH-assigned provider IDs incorporate a check-digit assigned by the following Modulus Eleven Check-Digit Routine. The algorithm is presented here so billing agents can verify the check-digit before submitting claims. This is provided as reference information only.

a)	Remove the right-most digit (the "check-digit") from the number to be verified and hold the number for a later comparison.
b)	Multiply each remaining digit by its position number, starting at the right-most place as number 1.
c)	Sum the results of ***step (b)***.
d)	Divide the sum by 11 and round up to the next highest integer. If the result is an integer, it should not be rounded off.
e)	Multiply the result of ***step (d)*** by 11.
f)	Subtract the result of ***step (c)*** from the result of ***step (e)***. For recipient ID Numbers, if the result is 10, the number is invalid by definition.
g)	Truncate all but the right-most digit of the result of ***step (f)***.
h)	Compare the result of ***step (g)*** with the number held in storage from ***step (a)***. If the numbers compared in ***step (h)*** are equal, the original ID numbers has the correct check-digit. If the recipient ID does not check, go to ***step (i)***.
i)	If the result of ***step (g)*** is greater than 4, subtract 5; otherwise, add 5.
j)	If this result still does not match the check-digit number stored in ***step (a)***, the recipient ID is invalid. The claim should be returned to the provider for correction.

EXAMPLE:

Provider ID Number: - 6375412

step a) – The numeral 2 is held in storage; the new number is 637541.

step b) –

number	6	3	7	5	4	1
position number	x6	x5	x4	x3	x2	x1
result	36	15	28	15	8	1

step c) – 36 + 15 + 28 + 15 + 8 + 1 = 103

step d) – 103/11 = 9.3, rounded up to 10

step e) – 10 x 11 = 110

step f) – 110 – 103 = 7

step g) – 7 = 7

step h) – 2 does not equal 7.

step I) – 7 > 4, therefore, subtract 5; 7 – 5 = 2. The number checks.

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B2 ANSI X12 837 CLAIM "ENVELOPES"

All electronic claims, professional and institutional, are sent within an electronic envelope that is made up of header and trailer records that signal the beginning and end of a submission. One format is used for the version 3051 Institutional claim, and a separate format is used for version 4010 of the Professional and Institutional claim. The 4010 Professional and Institutional claims are differentiated only by the value used in element GS08.

B2.1 837 Professional Claim, Version 3051

ICS Interchange Control Structures

Functional Group ID=

Introduction:

The purpose of this standard is to define the control structures for the electronic interchange of one or more encoded business transactions including the EDI (Electronic Data Interchange) encoded transactions of Accredited Standards Committee X12. This standard provides the interchange envelope of a header and trailer for the electronic interchange through a data transmission, and it provides a structure to acknowledge the receipt and processing of this envelope.

	Pos. No.	Seg. ID	Name	Req. Des.	Max.Use	Loop Repeat	Notes and Comments
M	010	ISA	Interchange Control Header	M	1		
	020	GS	Functional Group Header	O	1		
	030	GE	Functional Group Trailer	O	1		
M	040	IEA	Interchange Control Trailer	M	1		

B2.1 837 Professional Claim, Version 3051 (continued)

Segment: **ISA** **Interchange Control Header**
Position: 010
Loop:
Level:
Usage: Mandatory
Max Use: 1
Purpose: To start and identify an interchange of zero or more functional groups and interchange-related control segments
Syntax Notes:
Semantic Notes:
Comments:

Data Element Summary

	Ref. Des.	Data Element	Name		
	Attributes				
M	**ISA01**	**I01**	**Authorization Information Qualifier** Code to identify the type of information in the Authorization Information **Use "00"** **00** **No Authorization Information Present (No Meaningful Information in I02)**	**M**	**ID 2/2**
M	**ISA02**	**I02**	**Authorization Information** Information used for additional identification or authorization of the interchange sender or the data in the interchange; the type of information is set by the Authorization Information Qualifier (I01) **Space fill**	**M**	**AN 10/10**
M	**ISA03**	**I03**	**Security Information Qualifier** Code to identify the type of information in the Security Information **Use "00"** **00** **No Security Information Present (No Meaningful Information in I04)**	**M**	**ID 2/2**
M	**ISA04**	**I04**	**Security Information** This is used for identifying the security information about the interchange sender or the data in the interchange; the type of information is set by the Security Information Qualifier (I03) **Space fill**	**M**	**AN 10/10**
M	**ISA05**	**I05**	**Interchange ID Qualifier** Qualifier to designate the system/method of code structure used to designate the sender or receiver ID element being qualified **ZZ** **Mutually Defined**	**M**	**ID 2/2**
M	**ISA06**	**I06**	**Interchange Sender ID** Identification code published by the sender for other parties to use as the receiver ID to route data to them; the sender always codes this value in the sender ID element **Note:** **Positions 1-11: Space Fill** **Positions 12-15: Your Service Bureau ID number (00XX)**	**M**	**AN 15/15**
M	**ISA07**	**I05**	**Interchange ID Qualifier** Qualifier to designate the system/method of code structure used to designate the sender or receiver ID element being qualified **ZZ** **Mutually Defined**	**M**	**ID 2/2**

B2.1 837 Professional Claim, Version 3051 (continued)

M	**ISA08**	**I07**	**Interchange Receiver ID** Identification code published by the receiver of the data; When sending, it is used by the sender as their sending ID, thus other parties sending to them will use this as a receiving ID to route data to them **Note: ********** **Positions 1-9: Space Fill** **Positions 10-15: D00111**	**M**	**AN 15/15**
M	**ISA09**	**I08**	**Interchange Date** Date of the interchange **Format YYMMDD**	**M**	**DT 6/6**
M	**ISA10**	**I09**	**Interchange Time** Time of the interchange Format HHMM	**M**	**TM 4/4**
M	**ISA11**	**I10**	**Interchange Control Standards Identifier** Code to identify the agency responsible for the control standard used by the message that is enclosed by the interchange header and trailer **USE ONLY THE FOLLOWING VALUE:** **U U.S. EDI Community of ASC X12, TDCC, and UCS**	**M**	**ID 1/1**
M	**ISA12**	**I11**	**Interchange Control Version Number** This version number covers the interchange control segments **USE ONLY THE FOLLOWING VALUE:** **"00305" for version 3051**	**M**	**ID 5/5**
M	**ISA13**	**I12**	**Interchange Control Number** A control number assigned by the interchange sender **Must be identical to IEA02**	**M**	**N0 9/9**
M	**ISA14**	**I13**	**Acknowledgment Requested** Code sent by the sender to request an interchange acknowledgment (TA1) **MDCH will return a 997 upon completion of Translation. Enter the following value only.** **0 No Acknowledgment Requested**	**M**	**ID 1/1**
M	**ISA15**	**I14**	**Test Indicator** Code to indicate whether data enclosed by this interchange envelope is test or production **P Production Data** **T Test Data**	**M**	**ID 1/1**
M	**ISA16**	**I15**	**Component Element Separator** This field provides the delimiter used to separate component data elements within a composite data structure; this value must be different than the data element separator and the segment terminator **MDCH suggests that the following value be uses: ":" (colon)**	**M**	**AN 1/1**

B2.1 837 Professional Claim, Version 3051 (continued)

Segment: **GS** **Functional Group Header**
Position: 020
Loop:
Level:
Usage: Optional
Max Use: 1
Purpose: To indicate the beginning of a functional group and to provide control information
Syntax Notes:
Semantic Notes:
1 GS04 is the group date.
2 GS05 is the group time.
3 The data interchange control number GS06 in this header must be identical to the same data element in the associated functional group trailer, GE02.
Comments:
1 A functional group of related transaction sets, within the scope of X12 standards, consists of a collection of similar transaction sets enclosed by a functional group header and a functional group trailer.

Data Element Summary

Ref. Des. Attributes	Data Element	Name		
M **GS01**	**479**	**Functional Identifier Code** Code identifying a group of application related transaction sets **Use "HC"**	**M**	**ID 2/2**
M **GS02**	**142**	**Application Sender's Code** Code identifying party sending transmission; codes agreed to by trading partners **Use your Service Bureau ID Code, an example would be "00XX"**	**M**	**AN 4/4**
M **GS03**	**124**	**Application Receiver's Code** Code identifying party receiving transmission; codes agreed to by trading partners **Use "D00111"**	**M**	**AN 6/6**
M **GS04**	**373**	**Date** Date (YYMMDD) **Format YYMMDD**	**M**	**DT 6/6**
M **GS05**	**337**	**Time** Time expressed in 24-hour clock time as follows: HHMM, or HHMMSS, or HHMMSSD, or HHMMSSDD, where H = hours (00-23), M = minutes (00-59), S = integer seconds (00-59) and DD = decimal seconds; decimal seconds are expressed as follows: D = tenths (0-9) and DD = hundredths (00-99) **Format HHMM**	**M**	**TM 4/4**
M **GS06**	**28**	**Group Control Number** Assigned number originated and maintained by the sender **Must be identical to GE02**	**M**	**N0 1/9**
M **GS07**	**455**	**Responsible Agency Code** Code used in conjunction with Data Element 480 to identify the issuer of the standard **Use "X"** **X** **Accredited Standards Committee X12**	**M**	**ID 1/2**
M **GS08**	**480**	**Version / Release / Industry Identifier Code** Code indicating the version, release, subrelease, and industry identifier of the EDI standard being used, including the GS and GE segments; if code in DE455 in GS segment is X, then in DE 480 positions 1-3 are the version number; positions 4-6 are the release and subrelease, level of the version; and positions 7-12 are the industry or trade association identifiers (optionally assigned by user); if code in DE455 in GS segment is T, then other formats are allowed **Use "003051"** **003051** **Draft Standards Approved for Publication by ASC X12 Procedures Review Board through February 1995**	**M**	**AN 1/12**

B2.1 837 Professional Claim, Version 3051 (continued)

Segment: **GE** **Functional Group Trailer**
Position: 030
Loop:
Level:
Usage: Optional
Max Use: 1
Purpose: To indicate the end of a functional group and to provide control information
Syntax Notes:
Semantic Notes: **1** The data interchange control number GE02 in this trailer must be identical to the same data element in the associated Functional Header GS06.
Comments: **1** The use of identical data interchange control numbers in the associated functional group header and trailer is designed to maximize functional group integrity. The control number is the same as that used in the corresponding header.

Data Element Summary

	Ref. Des.	Data Element	Name	Attributes	
M	**GE01**	**97**	**Number of Transaction Sets Included** Total number of transaction sets included in the functional group or interchange (transmission) group terminated by the trailer containing this data element	**M**	**N0 1/6**
M	**GE02**	**28**	**Group Control Number** Assigned number originated and maintained by the sender	**M**	**N0 1/9**

B2.1 837 Professional Claim, Version 3051 (concluded)

Segment: **IEA** **Interchange Control Trailer**
Position: 040
Loop:
Level:
Usage: Mandatory
Max Use: 1
Purpose: To define the end of an interchange of zero or more functional groups and interchange-related control segments
Syntax Notes:
Semantic Notes:
Comments:

Data Element Summary

	Ref. Des.	Data Element	Name		
	Attributes				
M	**IEA01**	**I16**	**Number of Included Functional Groups** A count of the number of functional groups included in an interchange	**M**	**N0 1/5**
M	**IEA02**	**I12**	**Interchange Control Number** A control number assigned by the interchange sender Must be identical to ISA13	**M**	**N0 9/9**

B2.2 837 Professional and Institutional Claims, Version 4010

The electronic "envelope" for ANSI X12 837 Professional and Institutional claims in version 4010 are identical **except for** the values in element GS08.

ICS Interchange Control Structures

Functional Group ID=

Introduction:

The purpose of this standard is to define the control structures for the electronic interchange of one or more encoded business transactions including the EDI (Electronic Data Interchange) encoded transactions of Accredited Standards Committee X12. This standard provides the interchange envelope of a header and trailer for the electronic interchange through a data transmission, and it provides a structure to acknowledge the receipt and processing of this envelope.

	Pos. No.	Seg. ID	Name	Req. Des.	Max.Use	Loop Repeat	Notes and Comments
M	010	ISA	Interchange Control Header	M	1		
M	020	GS	Functional Group Header	M	1		
M	030	GE	Functional Group Trailer	M	1		
M	040	IEA	Interchange Control Trailer	M	1		

B2.2 837 Professional and Institutional Claims, Version 4010 (continued)

Segment: **ISA** **Interchange Control Header**
Position: 010
Loop:
Level:
Usage: Mandatory
Max Use: 1
Purpose: To start and identify an interchange of zero or more functional groups and interchange-related control segments
Syntax Notes:
Semantic Notes:
Comments:

Data Element Summary

	Ref. Des. Attributes	Data Element	Name		
M	**ISA01**	**I01**	**Authorization Information Qualifier** Code to identify the type of information in the Authorization Information **USE THE FOLLOWING VALUE ONLY:** **00** **No Authorization Information Present (No Meaningful Information in I02)**	**M**	**ID 2/2**
M	**ISA02**	**I02**	**Authorization Information** Information used for additional identification or authorization of the interchange sender or the data in the interchange; the type of information is set by the Authorization Information Qualifier (I01) **SPACE FILL**	**M**	**AN 10/10**
M	**ISA03**	**I03**	**Security Information Qualifier** Code to identify the type of information in the Security Information **USE ONLY THE FOLLOWING VALUE:** **00** **No Security Information Present (No Meaningful Information in I04)**	**M**	**ID 2/2**
M	**ISA04**	**I04**	**Security Information** This is used for identifying the security information about the interchange sender or the data in the interchange; the type of information is set by the Security Information Qualifier (I03) **SPACE FILL.**	**M**	**AN 10/10**
M	**ISA05**	**I05**	**Interchange ID Qualifier** Qualifier to designate the system/method of code structure used to designate the sender or receiver ID element being qualified USE ONLY THE FOLLOWING VALUE: ZZ Mutually Defined	**M**	**ID 2/2**
M	**ISA06**	**I06**	**Interchange Sender ID** Identification code published by the sender for other parties to use as the receiver ID to route data to them; the sender always codes this value in the sender ID element **NOTE XXXXXXXXX** **Position 1-11: Space Fill** **Position 12-15: Your Service Bureau ID Number (00XX)**	**M**	**AN 15/15**
M	**ISA07**	**I05**	**Interchange ID Qualifier** Qualifier to designate the system/method of code structure used to designate the sender or receiver ID element being qualified **USE ONLY THE FOLLOWING VALUE:** **ZZ** **Mutually Defined**	**M**	**ID 2/2**

B2.2 837 Professional and Institutional Claims, Version 4010 (continued)

M	**ISA08**	**I07**	**Interchange Receiver ID** Identification code published by the receiver of the data; When sending, it is used by the sender as their sending ID, thus other parties sending to them will use this as a receiving ID to route data to them **NOTE XXXXXXXXX** **Position 1-9: Space Fill** **Position 10-15: Enter the value: "D00111"**	**M**	**AN 15/15**
M	**ISA09**	**I08**	**Interchange Date** Date of the interchange **Format is YYMMDD** **An example for the date, December 31, 2001 you would use: 011231**	**M**	**DT 6/6**
M	**ISA10**	**I09**	**Interchange Time** Time of the interchange **The format is HHMM** **Where H = Hours (0-23) and M = Minutes (0-59).** **An Example for 02:00 p.m.** **you would use: 1400**	**M**	**TM 4/4**
M	**ISA11**	**I10**	**Interchange Control Standards Identifier** Code to identify the agency responsible for the control standard used by the message that is enclosed by the interchange header and trailer **USE ONLY THE FOLLOWING VALUE:** **U U.S. EDI Community of ASC X12, TDCC, and UCS**	**M**	**ID 1/1**
M	**ISA12**	**I11**	**Interchange Control Version Number** This version number covers the interchange control segments **USE ONLY THE FOLLOWING VALUE:** **00401 Draft Standards for Trial Use Approved for Publication by ASC X12 Procedures Review Board through October 1997**	**M**	**ID 5/5**
M	**ISA13**	**I12**	**Interchange Control Number** A control number assigned by the interchange sender **Must be identical to IEA02**.	**M**	**N0 9/9**
M	**ISA14**	**I13**	**Acknowledgment Requested** Code sent by the sender to request an interchange acknowledgment (TA1) **MDCH will provide a 997 Acknowledgment when translation complets.** **Use only the following value:** **0 No Acknowledgment Requested**	**M**	**ID 1/1**
M	**ISA15**	**I14**	**Usage Indicator** Code to indicate whether data enclosed by this interchange envelope is test, production or information **NOTE:** **MDCH will Route and Process this based upon the value selected.** **P Production Data** **T Test Data**	**M**	**ID 1/1**
M	**ISA16**	**I15**	**Component Element Separator** Type is not applicable; the component element separator is a delimiter and not a data element; this field provides the delimiter used to separate component data elements within a composite data structure; this value must be different than the data element separator and the segment terminator **MDCH suggests you use ":" (colon) as the Component Element Separator.**	**M**	**AN 1/1**

B2.2 837 Professional and Institutional Claims, Version 4010 (continued)

Segment: **GS** **Functional Group Header**
Position: 020
Loop:
Level:
Usage: Mandatory
Max Use: 1
Purpose: To indicate the beginning of a functional group and to provide control information
Syntax Notes:
Semantic Notes:
1 GS04 is the group date.
2 GS05 is the group time.
3 The data interchange control number GS06 in this header must be identical to the same data element in the associated functional group trailer, GE02.
Comments:
1 A functional group of related transaction sets, within the scope of X12 standards, consists of a collection of similar transaction sets enclosed by a functional group header and a functional group trailer.

Data Element Summary

	Ref. Des. Attributes	Data Element	Name		
M	**GS01**	**479**	**Functional Identifier Code** Code identifying a group of application related transaction sets **HC Health Care Claim (837)**	**M**	**ID 2/2**
M	**GS02**	**142**	**Application Sender's Code** Code identifying party sending transmission; codes agreed to by trading partners **Use your Service Bureau ID Code. An example would be "00XX"**	**M**	**AN 2/15**
M	**GS03**	**124**	**Application Receiver's Code** Code identifying party receiving transmission; codes agreed to by trading partners **Use only the following value "D00111" for Medicaid.**	**M**	**AN 2/15**
M	**GS04**	**373**	**Date** Date expressed as CCYYMMDD **Semantic: GS04 is the Group Date.** **Use this date for the Functional Group Creation Date.**	**M**	**DT 8/8**
M	**GS05**	**337**	**Time** Time expressed in 24-hour clock time as follows: HHMM, or HHMMSS, or HHMMSSD, or HHMMSSDD, where H = hours (00-23), M = minutes (00-59), S = integer seconds (00-59) and DD = decimal seconds; decimal seconds are expressed as follows: D = tenths (0-9) and DD = hundredths (00-99) **Semantic: GS05 is the Group Time.** **Use this time for the creation time. The recommended format is HHMM.**	**M**	**TM 4/8**
M	**GS06**	**28**	**Group Control Number** Assigned number originated and maintained by the sender **Semantic: The data interchange control number GS06 in this header must be identical to the same data element in the associated functionl group trailer GE02.**	**M**	**N0 1/9**
M	**GS07**	**455**	**Responsible Agency Code** Code used in conjunction with Data Element 480 to identify the issuer of the standard **Use only the following value:** **X Accredited Standards Committee X12**	**M**	**ID 1/2**

B2.2 837 Professional and Institutional Claims, Version 4010 (continued)

M	**GS08**	**480**	**Version / Release / Industry Identifier Code** Code indicating the version, release, subrelease, and industry identifier of the EDI standard being used, including the GS and GE segments; if code in DE455 in GS segment is X, then in DE 480 positions 1-3 are the version number; positions 4-6 are the release and subrelease, level of the version; and positions 7-12 are the industry or trade association identifiers (optionally assigned by user); if code in DE455 in GS segment is T, then other formats are allowed	**M AN 1/12**

Use only one of the following codes:

Code	Definition
"004010X098"	**This is to identify Version Number 4010, of the ASC X12 837 Profession Health Care Invoice.**
"004010X096"	**This is to identify Version Number 4010. of the ASC X12 837 Institutional Health Care Invoice.**

B2.2 837 Professional and Institutional Claims, Version 4010 (continued)

Segment: GE Functional Group Trailer
Position: 030
Loop:
Level:
Usage: Mandatory
Max Use: 1
Purpose: To indicate the end of a functional group and to provide control information
Syntax Notes:
Semantic Notes: **1** The data interchange control number GE02 in this trailer must be identical to the same data element in the associated functional group header, GS06.
Comments: **1** The use of identical data interchange control numbers in the associated functional group header and trailer is designed to maximize functional group integrity. The control number is the same as that used in the corresponding header.

Data Element Summary

Ref. Des. Attributes	Data Element	Name		
M GE01	**97**	**Number of Transaction Sets Included** Total number of transaction sets included in the functional group or interchange (transmission) group terminated by the trailer containing this data element	**M**	**N0 1/6**
M GE02	**28**	**Group Control Number** Assigned number originated and maintained by the sender Semantic: The data interchange control number GE02 in this trailer must be identical to the same data element in the associated functional group herder, GS06.	**M**	**N0 1/9**

B2.2 837 Professional and Institutional Claims, Version 4010 (concluded)

Segment: **IEA** **Interchange Control Trailer**
Position: 040
Loop:
Level:
Usage: Mandatory
Max Use: 1
Purpose: To define the end of an interchange of zero or more functional groups and interchange-related control segments
Syntax Notes:
Semantic Notes:
Comments:

Data Element Summary

	Ref. Des. Attributes	Data Element	Name		
M	IEA01	I16	**Number of Included Functional Groups** A count of the number of functional groups included in an interchange	M	N0 1/5
M	IEA02	I12	**Interchange Control Number** A control number assigned by the interchange sender	M	N0 9/9

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CONTENTS

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C1 REMITTANCE ADVICE

C1.1 Proprietary Remittance Advice (R866 and R867)

OUTPUT RECORD — REMITTANCE ADVICE CLAIM RECORD — R866

RECORD NAME: Remittance Advice Claim Record		**RECORD TYPE: 866**		**RECORD SIZE: 360 POSITION**	
FIELD #	FIELD NAME	PICTURE	JUSTIFIED	FROM	THRU
1	Record Type 866 "Value is "866"	9(3)	“866”	01	03
2	Pay Cycle Number	9(2)	R	04	05
3	Billing Agent Number	X(4)	R	06	09
4	Prev-Pend-Flag	9(1)	R	10	10
5	Filler	X(3)		11	13
6	Claim Reference Number				
	Julian Date	9(4)	R	14	17
	Sequence Number	9(6)	R	18	23
7	Filler – 1	X(2)		24	25
8	Claim Reference Line Number	9(2)	R	26	27
9	Supp Record Flag	9(1)	R	28	28
10	Adjustment Code	9(1)	R	29	29
11	Filler	X(7)		30	36
12	Provider Type	9(2)	L	37	38
13	Provider ID Number	9(7)	L	39	45
14	Recipient Name	X(20)	L	46	65
15	Filler	X(2)		66	67
16	Recipient ID Number	9(8)	L	68	75
17	Provider Reference Number	X(14)	L	76	89
18	Prescription Number	X(10)	R	90	99
19	Invoice Date	9(6)	R	100	105
20	Service Date	9(6)	R	106	111
21	Diagnosis-Section				
	Diagnosis Code 1	X(5)	L	112	116
	Diagnosis Code 2	X(5)	L	117	121
	Diagnosis Code 3	X(5)	L	122	126
22	Surgical Procedure				
	Surgical Procedure 1	X(6)	R	127	132
	Surgical Procedure 2	X(6)	R	133	138
	Surgical Procedure 3	X(6)	R	139	144
23	Tooth-Section (**Redefines R866-Surgical-Proc-Section)**				
	Tooth-Number-Letter	X(2)	R	127	128
	Tooth-Surface-Code	X(6)	R	129	134
	Filler	X(10)		135	144
24	Procedure Section				

C1.1 Proprietary Remittance Advice (R866 and R867)

OUTPUT RECORD — REMITTANCE ADVICE CLAIM RECORD — R866 (continued)

RECORD NAME: Remittance Advice Claim Record		RECORD TYPE: 866		RECORD SIZE: 360 POSITION	
FIELD #	FIELD NAME	PICTURE	JUSTIFIED	FROM	THRU
	Procedure Code	X(6)	R	145	150
	Procedure Type	X(2)	R	151	152
	Filler	X(16)		153	168
25	Drug Section **(Redefines R866 Procedure-Section)**				
	Drug-ID-Number	X(12)	R	145	156
	NDC-Drug-ID-Number	X(12)	R	157	168
26	HMO Section **(Redefines R866 Procedure Section)**				
	Recipient Age	9(3)	R	145	147
	Recipient Program	X(1)	R	148	148
	Recipient County Code	9(2)	R	149	150
	Recipient Sex	9(1)	R	151	151
	Filler	X(17)		152	168
27	IPH-Days-Section **(Redefines R866 Procedure Section)**				
	Number-Covered-Days	9(3)	R	145	147
	Filler	X(21)		148	168
28	Quantity-Area				
	Quantity	9(5)	R	169	173
	Quantity-Fraction	V9(3)	R	174	176
29	Amount Billed	9(8)V99	R	177	186
30	Number of Payors	9(1)	R	187	187
31	Source Status Section (Occurs 5 times)				
	Source Status Code	X(1)	R	188	188
	Amount Approved	9(7)V99	R	189	197
	Source Status Code	X(1)	R	198	198
	Amount Approved	9(7)V99	R	199	207
	Source Status Code	X(1)	R	208	208
	Amount Approved	9(7)V99	R	209	217
	Source Status Code	X(1)	R	218	218
	Amount Approved	9(7)V99	R	219	227
	Source Status Code	X(1)	R	228	228
	Amount Approved	9(7)V99	R	229	237
32	Explanation Code Section (Occurs 10 times)				
	Explanation Code	9(4)	R	238	241
	Force-Flag	9(1)	R	242	242
	Explanation Code	9(4)	R	243	246
	Force-Flag	9(1)	R	247	247

C1.1 Proprietary Remittance Advice (R866 and R867)

OUTPUT RECORD — REMITTANCE ADVICE CLAIM RECORD — R866 (concluded)

RECORD NAME: Remittance Advice Claim Record		RECORD TYPE: 866		RECORD SIZE: 360 POSITION	
	Explanation Code	9(4)	R	448	251
	Force-Flag	9(1)	R	252	252
	Explanation Code	9(4)	R	253	256
	Force-Flag	9(1)	R	257	257
	Explanation Code	9(4)	R	258	261
	Force-Flag	9(1)	R	262	262
	Explanation Code	9(4)	R	263	266
	Force-Flag	9(1)	R	267	267
	Explanation Code	9(4)	R	268	271
	Force-Flag	9(1)	R	272	272
	Explanation Code	9(4)	R	273	276
	Force-Flag	9(1)	R	277	277
	Explanation Code	9(4)	R	278	281
	Force-Flag	9(1)	R	282	282
	Explanation Code	9(4)	R	283	286
	Force-Flag	9(1)	R	287	287
33	Date of Payment	9(6)	R	288	293
34	Discharge-Status-Code	X(1)	R	294	294
35	DRG Code	X(4)	R	295	298
36	Modifier 1	X(2)	R	299	300
37	Modifier 2	X(2)	R	301	302
38	Filler	X(3)		303	305
39	Prior Authorization Number	X(9)	R	306	314
40	Place of Service	X(2)	R	315	316
41	Input Batch Number	X(5)	R	317	321
42	Filler	X(3)		322	324
43	Billing Bureau CRN	X(10)	R	325	334
44	Filler	X(12)		335	346
45	Source of Submission	X(4)	R	347	350
46	Filler	X(10)		351	360

C1.1 Proprietary Remittance Advice (R866 and R867)

OUTPUT RECORD — REMITTANCE ADVICE CLAIM RECORD — R866

FIELD	LOCATION & POSITION	FIELD NAME AND DESCRIPTION
1	1-3 9(3)	**Record Code** A three-character numeric field used to identify the record type. The Record Code does not appear on the paper Remittance Advice. All R866 records have a constant value of "866" in this field.
2	4-5 9(2)	**Pay Cycle Number** This is two-character numeric field used to identify the pay cycle on which the R866 record produced. The Pay Cycle number may be found in the upper portion of the paper Remittance Advice under the heading Pay Cycle. The Medical Services Administration assigns a sequential number to each Pay Cycle, beginning with 01 for the first pay cycle in the year, and ending at 52 for the last pay cycle in the year. Additional pay cycles are numbers greater than 52. The Pay Cycle is right-justified and left zero-filled.
3	6-9 X(4)	**Billing Agent Number** A four-character alphanumeric field, which identifies the method used to enter the claim into the IP System. For each Billing Agent Number, the claim identifier is a constant value equal to the four-digit alpha or numeric Billing Agent Number assigned to the Billing Agent.
4	10-10 9(1)	**Prev.-Pend-Flag** A one-character numeric field used to identify whether the claim reported in this R866 record is new input on this pay cycle or entered this pay cycles from the pended claims file. New claims will have a zero in this field; Previously Pended claims will have a **"1."** The Previous Pend Flag does not appear on the paper Remittance Advice.
5	11-13 X(3)	**Filler** This is three-character alphanumeric field whose value is space.
6		**Claim Reference Number** A ten-character field used to identify the CRN assigned to the claim reported in the R866 record. The Claim Reference Number may be found on the paper Remittance Advice under the heading Claim Reference Number. The Claim Reference Number is composed of two subfields, the ***Julian Date*** and ***Sequence Number***.
	14-17 9(4)	**CRN Julian Date** A four-character numeric subfield corresponding to the left-most four characters of the Claim Reference Number ***(R101-03A*)** field on the claim reported on this R866 record.
	18-23 9(6)	**CRN Sequence Number** A six-character numeric subfield corresponding to the right-most six characters of the Claim Reference field number on the claim reported in this R866 record.
7	24-25 X(2)	**Filler** A two-character alphanumeric field whose value is space.

C1.1 Proprietary Remittance Advice (R866 and R867)

OUTPUT RECORD — REMITTANCE ADVICE CLAIM RECORD — R866 (continued)

FIELD	LOCATION & POSITION	FIELD NAME AND DESCRIPTION
8	26-27 9(2)	**Claim Line Number** A two-character numeric field used to indicate the line number of the claim being reported. The Claim Reference Line Number may be found on the paper Remittance Advice under the heading "Line No." The Claim Reference Line Number corresponds to the claim line number ***(R102-05*)** on the claim submitted and reported in this R866 record. The Claim Reference Line Number is right-justified and left zero-filled.
9	28-28 9(1)	**Supp. Record Flag** A one-character numeric field used to identify whether this record is an R866 record or and R867 record. The Suppmential Record Flag does not appear on the paper Remittance Advice. ***This field is used by the Medical Services Administration for ease in sorting and contains the value of "0" in this field.***
10	29-29 9(1)	**Adjustment-Code** A one-character numeric field used to identify whether the claim reported in the R866 record is an invoice transaction or an adjustment transaction. The Adjustment Code does not appear on the paper remittance advice. The adjustment code corresponds to the Adjustment Reason Code (R101-36) on the invoice/adjustment submitted and reported in this R866 record.
11	30-36 X(7)	**Filler** A seven-character alphanumeric field whose value is space.
12	37-38 9(2)	**Provider-Type** A two-character numeric field used to report the type of provider for whom the claim was submitted. The Provider Type may be found in the upper area of the paper remittance advice under the heading "Provider Type." The Provider Type corresponds to the Provider Type (R101-09) on the claim reported in this R866 record.
13	39-45 9(7)	**Provider ID Number** A seven-character numeric field used to report the provider for whom the claim was submitted. The Provider ID Number may be found in the upper area of the paper Remittance Advice under the heading "Provider ID No." The Provider ID Number corresponds to the Provider ID number (R101-10) on the claim reported in this R866 record.

C1.1 Proprietary Remittance Advice (R866 and R867)

OUTPUT RECORD — REMITTANCE ADVICE CLAIM RECORD — R866 (continued)

FIELD	LOCATION & POSITION	FIELD NAME AND DESCRIPTION
14	46-65 X(20)	**Recipient Name** A twenty-character alphanumeric field used to report the name of the recipient for whom the claim was billed. The Recipient Name may be found on the paper Remittance Advice to the right of the header "Recipient Name." The recipient name should correspond to the recipient name on (R003-08) on the claim reported in this R866 record. The Recipient Name, however, is reported form the Recipient Identification Number (R101-08) form the claim submitted as it will report the Recipient Name as it is on the MDCH recipient files. The Recipient Name is left-justified and right spaced filled.
15	66-67 X(2)	**Filler** A two-character alphanumeric field whose value is space.
16	68-75 9(8)	**Recipient ID Number** An eight-character numeric field used to identify the recipient for whom the claim was billed. The Recipient ID Number may be found on the paper Remittance Advice to the right of the header "Recipient ID Number." The Recipient ID Number corresponds to the Recipient ID Number (R101-08) on the claim reported in this R866 record
17	76-89 X(14)	**Provider Reference Number** A fourteen-character alphanumeric field used to report the Provider Reference Number on the claim being reported. The Provider Reference Number corresponds to the Provider Reference Number ***(R101-13*)** on the claim reported in this R866 record. The Provider Reference Number is justified and filled as submitted.
18	90-99 X(10)	**Prescription Number** This is a ten-character alphanumeric field used to report the Prescription Number associated with the claim being reported. The prescription number may be found on the paper Remittance Advice for applicable invoice types under the heading "Prescription NO." The Prescription number corresponds to the Prescription Number (R102-15) on the claim reported in this R866 record. The Prescription number is right-justified and left zero-filler. **When the Prescription Number (R102) is used on invoice types other than pharmacy, it will not appear**
19	100-105 9(6)	**Invoice Date** A six-character numeric field of the format ***"MMDDYY"*** used to report the date the claim was prepared. The Invoice Date may be found on the paper Remittance Advice under the heading "Invoice Date." The Invoice Date corresponds to the Invoice Date ***(R101-47*)** on the claim reported in this R866 record. The Invoice Date is right-justified and left zero-filled.

C1.1 Proprietary Remittance Advice (R866 and R867)

OUTPUT RECORD — REMITTANCE ADVICE CLAIM RECORD — R866 (continued)

FIELD	LOCATION & POSITION	FIELD NAME AND DESCRIPTION
20	106-111 9(6)	**Service Date** A six-character numeric field of the format ***"MMDDYY"*** used to report the date the services were provided, or the first date of a period of time covered by the claim. The Service Date may be found on the paper Remittance Advice under the heading "Service Date." The Service Date corresponds to the date of service ***(R102-11)*** depending on the invoice type on the claim reported in this R866 record. The Service Date is right-justified and left zero-filled.
21		**Diagnosis Section**
	112-116 X(5)	**Diagnosis-Code 1** A five-character alphanumeric subfield used to report the primary diagnosis code on the claim. The Diagnosis Code may be found on the paper Remittance Advice for applicable invoice types under the heading "Diagnosis Code." The Diagnosis Code corresponds to the primary diagnosis ***(R102-07)*** on the claim reported in this R866 record. The Diagnosis Code is left-justified and right space-filled.
	117-121 X(5)	**Diagnosis Code 2** This is a ICD-9-CM diagnosis code that the provider has billed.
	122-126 X(5)	**Diagnosis Code 3** This is a ICD-9-CM diagnosis code that the provider has billed.
22		**Surgical Procedure Section**
	127-132 X(6)	**Surgical Procedure 1** This is an ICD-9-CM surgical procedure code that the hospital has billed.
	133-138 X(6)	**Surgical Procedure 2** This is an ICD-9-CM surgical procedure code that the hospital has billed.
	139-144 X(6)	**Surgical Procedure 3** This is an ICD-9-CM surgical procedure code that the hospital has billed.
23		**Tooth Section (Redefines R866 Surgical Procedure Section)** An eight-character alphanumeric field which redefines the R866 diagnosis and contains the following subfields:
	127-128 X(2)	**Tooth Number/Letter** A two-character alphanumeric subfield used to report the Tooth Number or Letter on which the procedure was performed. The Tooth Number/Letter may be found on the paper Remittance Advice for applicable invoice types under the heading "Tooth N/L/S." The Tooth Number/Letter corresponds to the Tooth Number/Letter (R102-17) on the claim reported in this R866 record. The Tooth Number/Letter is left-justified and right space-filled.

C1.1 Proprietary Remittance Advice (R866 and R867)

OUTPUT RECORD — REMITTANCE ADVICE CLAIM RECORD — R866 (continued)

FIELD	LOCATION & POSITION	FIELD NAME AND DESCRIPTION
	129-134 X(6)	**Tooth Surface Code** A six-character alphanumeric subfield used to report the tooth surface on which the procedure was performed. The Tooth Surface Code may be found on the paper Remittance Advice for applicable invoice types under the heading "Tooth N/L/S." The Tooth Surface Code corresponds to the Tooth Surface Code (R102-18) on the claim reported in this R866 record. The Tooth Surface Code is left-justified and right space-filled.
	135-144 X(10)	**Filler** A ten-character alphanumeric field whose value is space.
24		**Procedure Section** An eight-character alphanumeric field which contains the following subfields:
	145-150 9(6)	**Procedure Code** A six-character alphanumeric subfield used to report the procedure code. The procedure code may be found on the paper Remittance Advice for applicable invoice types under the heading "Procedure Code/Type." The procedure code corresponds to the procedure code ***(R102-05)*** on the claim reported in this R866 record. The procedure code is right-justified and left zero filled.
	151-152 X(2)	**Procedure Type** A two-character alphanumeric subfield used to report the procedure type. The procedure type may be found on the paper Remittance Advice for applicable invoice types under the heading "Procedure Code/Type." The procedure type corresponds to the procedure type ***(R102-06)*** on the claim reported in this R866 record. The procedure type right-justified and left zero-filled.
	153-168 X(16)	**Filler** A sixteen-character alphanumeric field whose value is space.
25		**Drug Section (Redefines the R866 Procedure Section)**
	145-156 X(12)	Drug ID Number *Not Used anymore
	157-168 X(12)	**NDC Drug-ID-Number** National Drug Code Billed by Pharmacy
26		**HMO Section (Redefines R866 Procedure Section)**
	145-147 9(3)	**Recipient Age** A three-character numeric sub-field used to report the age of the recipient. The Recipient Age is obtained from MDCH files for the Recipient ID Number contained in the Recipient Identification Number ***(R101-08)*** on the claim reported in this R866 record. The recipient age sub-field is right-justified and left zero-filled.

C1.1 Proprietary Remittance Advice (R866 and R867)

OUTPUT RECORD — REMITTANCE ADVICE CLAIM RECORD — R866 (continued)

FIELD	LOCATION & POSITION	FIELD NAME AND DESCRIPTION
	148-148 X(1)	**Recipient Program** A one-character alphanumeric sub-field used to report the MDCH program in which the recipient is enrolled. The Recipient Program Code may be found on the paper Remittance Advice for applicable invoice types under the headline "Procedure Code/Type." The Recipient Program Code is obtained from MDCH files for the Recipient ID Number in the Recipient Identification Number ***(R101-08)*** on the claim reported in this R866 record.
	149-150 9(2)	**Recipient County Code** A two-character numeric sub-field used to report the county in which the recipient resides. The Recipient County Code may be found on the paper Remittance Advice for applicable invoice types under the heading "Procedure Code/Type." The Recipient County Code is obtained from MDCH files for the Recipient ID Number contained in the recipient identification number ***(R101-08)*** on the claim reported in this R866 record.
	151-151 9(1)	**Recipient Sex** A one-character numeric sub-field used to report the sex of the recipient. The Recipient Sex may be found on the paper Remittance Advice for applicable invoice types under the heading "Procedure Code/Type." The recipient sex is obtained from MDCH files for the Recipient ID Number contained in the Recipient Identification Number ***(R101-08)*** on the claim reported in this R866 record.
	152-168 X(17)	**Filler** A seventeen-character alphanumeric field whose value is space.
27		**IPH Days Section (Redefines R866 Procedure Section)** An eight-character alphanumeric filler which redefines the R866 procedure and contains the following subfields:
	145-147 9(3)	**Number Covered Days** A three-character numeric subfield used to report the number of inpatient days billed. The number covered days may be found on the paper Remittance Advice for applicable invoice types under the heading "Procedure Code/Type." The number covered days corresponds to the number days/visits (R101-41) on the claim reported in this R866 record. The number covered days is right-justified and left zero-filled.
	148-168 X(21)	**Filler** A twenty-one-character alphanumeric field whose value is space.
28		Quantity Area
	169-173 9(5)	**Quantity** A five-character numeric field used to report the quantity of services billed. The quantity may be found on the paper Remittance Advice for applicable invoice types under the heading "Quantity." The quantity corresponds to the quantity (R102-09) on the claim reported in this R866 record. The quantity is right-justified and left zero-filled

C1.1 Proprietary Remittance Advice (R866 and R867)

OUTPUT RECORD — REMITTANCE ADVICE CLAIM RECORD — R866 (continued)

FIELD	LOCATION & POSITION	FIELD NAME AND DESCRIPTION
	174-176 V9(3)	**Quantity Decimal** A three-character numeric field used by Pharmacy to report fractions.
29	177-186 9(8)V99	**Amount Billed** A ten-character numeric field of the format 9(8)V99 used to report the amount billed. The Amount Billed may be found on the paper Remittance Advice under the heading "Amount Billed." The amount billed corresponds to the Amount Billed (***R102-34)*** on the claim reported in this R866 record. The amount billed is right-justified and left zero-filled.
30	187-187 9(1)	**Number of Payors** A one-character numeric field used to indicate the Number of Payors ***(number of source/status occurrences, R866-31, which contain payment data)*** on approved claims. The value of the Number of Payors will correspond to the number of sources listen on the paper Remittance Advice for the corresponding approved claim. ***Valid codes are all integer values from "0" to "5" inclusive.***
31	188-237	**Source Status Section** A ten-character alphanumeric field, which occurs five times. Each occurrence of the source/status contains the following subfields:
	X(1)	**Source Status Code** A one-character alphanumeric subfield used to report the status of the claim. The Source or Status Code may be found on the paper Remittance Advice under the heading "Source/Status Code." Valid codes for the source status code are defined on the following page: *(See Source Status Table on next page.)*

C1.1 Proprietary Remittance Advice (R866 and R867)

OUTPUT RECORD — REMITTANCE ADVICE CLAIM RECORD — R866 (continued)

<table>
<tr><th>FIELD</th><th>LOCATION & POSITION</th><th>FIELD NAME AND DESCRIPTION</th></tr>
<tr><td></td><td></td><td>
<table>
<tr><th>Source/Status Code Table</th><th>Providers Participating in M.P. Programs</th><th>Non MIP. Providers</th></tr>
<tr><td>Claim rejected by the IP System without further processing (system reject)</td><td>1</td><td>1</td></tr>
<tr><td>Claim rejected to the provider for reasons indicated by explanation codes.</td><td>2</td><td>2</td></tr>
<tr><td>Claim pended for manual review or quarterly processing for reasons indicated by explanation codes.</td><td>4</td><td>4</td></tr>
<tr><td>Amount approved applies to Medicare coinsurance and/or deductible amount.</td><td>M</td><td>M</td></tr>
<tr><td>Amount approved indicates an amount previously paid (relates to claim replacement).</td><td>P</td><td>P</td></tr>
<tr><td>Amount approved is from Medicaid funds.</td><td>R</td><td>A</td></tr>
<tr><td>Amount approved is from Crippled Children funds.</td><td>S</td><td>B</td></tr>
<tr><td>Amount approved is from both Medicaid and Crippled Children funds</td><td>T</td><td>C</td></tr>
<tr><td>Amount approved is from General Assistance Funds</td><td>U</td><td>D</td></tr>
<tr><td>Amount approved is from Refugee/Repatriate Funds</td><td>V</td><td>E</td></tr>
<tr><td>Amount approved is from Resident County Hospitalization Funds</td><td>F</td><td>F</td></tr>
</table>
</td></tr>
<tr><td></td><td>9(7)V99</td><td>Amount Approved
A nine-character numeric subfield of the format 9(7)V99 used to indicate the amount paid to or withheld from (if claim replacement) the provider by the Medical Services Administration for the claim line reported in this R866 record. The Amount Approved may be found on the paper Remittance Advice under the heading "Amount Approved." The Amount Approved right-justified and left zero-filled.

The Amount Approved is a signed field.</td></tr>
<tr><td>32</td><td>238-287</td><td>Explanation Section
A five-character alphanumeric field, which occurs ten times. Each occurrence of the explanation contains the following subfields:</td></tr>
</table>

C1.1 Proprietary Remittance Advice (R866 and R867)

OUTPUT RECORD — REMITTANCE ADVICE CLAIM RECORD — R866 (continued)

FIELD	LOCATION & POSITION	FIELD NAME AND DESCRIPTION
	9(4)	**Explanation Code** A four-character numeric subfield used to indicate a condition on the claim detected by the IP system. Explanation codes may be reported for approved claims as well as for those, which are pended or rejected. The Explanation Code(s) may be found on the paper Remittance Advice under the heading "Explanation Codes or Comments."
	9(1)	**Force Flag** A one-character numeric field used to report whether the explanation code(s) contained in the corresponding explanation code subfield was manually forced through IP system. The Force Flag is indicated on the paper Remittance Advice by an asterisk following the applicable explanation code under the heading "Explanation Codes or Comments." Valid codes for the Force Flag are as follows: ***0 = edit unforced (blank on paper Remittance Advice)*** ***1 = edit forced (asterisk on paper Remittance Advice)***
33	288-293 9(6)	**Date of Payment** A six-character numeric field of the format ***"MMDDYY"*** used to indicate the date the payment transaction was posted by the Medical Services Administration for the claim line The date of payment may be found on the paper Remittance Advice under the heading "Pay Date." The date of payment is right-justified and left zero-filled.
34	294-294 9(1)	**Discharge Status Code** This is from Institutional Billings (LTC, Inpatient) 1 = Discharge 2 = Deceased 3 = Transferred to Long Term Care 4 = Transferred to Home Health 5 = Not Discharged 6 = Transferred to Other Inpateint Hospital 7 = Additional page of a multi-page invoice 8 = Late Charges Only
35	295-298 X(4)	**DRG Code** The DRG Grouper that we assigned and paid the Inpatient Hospital Claim under.
36	299-300 X(2)	**Modifier 1** Refer to Michigan Procedure Coding Manuals, UB-92 Manual, and/or the Medicaid Provider Manuals.
37	301-302 X(2)	**Modifier 2** Refer to Michigan Procedure Coding Manuals, UB-92 Manual, and/or the Medicaid Provider Manuals.

C1.1 Proprietary Remittance Advice (R866 and R867)

OUTPUT RECORD — REMITTANCE ADVICE CLAIM RECORD — R866 (concluded)

FIELD	LOCATION & POSITION	FIELD NAME AND DESCRIPTION
38	303-305 X(3)	**Filler** A three-character alphanumeric field whose value is space.
39	306-314 X(9)	**Prior Authorization Number** Enter the 9 digit authorization number, If applicable.
40	315-316 X(2)	**Place of Service** Refer to Michigan Procedure Coding Manuals, UB-92 Manual, and/or the Medicaid Provider Manuals.
41	317-321 X(5)	**Input Batch Number** This is the Batch Number of the Group of Claims that this Claim was submitted by the Billing Agent on the R106 record.
42	322-324 X(3)	**Filler** A three-character alphanumeric field whose value is space.
43	325-334 X(10)	**Billing Agent CRN** This is the Claim Reference Number that the Billing Agent assigned to the claim in field “03” , R101, R102, R103.
44	335-346 X(12)	**Filler** A twelve-character alphanumeric field whose value is space.
45	347-350 X(4)	**Source of Submission** The service bureau ID Number that submitted the invoice.
46	351-360 X(10)	**Filler** A ten-character alphanumeric field whose value is space.

C1.1 Proprietary Remittance Advice (R866 and R867)

OUTPUT RECORD TYPE 867: REMITTANCE ADVICE

RECORD NAME: Remittance Advice – Supplemental Record		**RECORD TYPE: 867**		**RECORD SIZE: 360 POSITION**	
FIELD #	FIELD NAME	PICTURE	JUSTIFIED	FROM	THRU
1	Record Type 867	9(3)	"867"	01	03
2	Pay Cycle Number	9(2)	R	04	05
3	Billing Agent Number	X(4)	R	06	09
4	Prev pend Flag	9(1)	R	10	10
5	Filler	X(3)		11	13
6	Claim Reference Number				
6A	CRN Julian Date	9(4)	R	14	17
6B	CRN Sequence Number	9(6)	R	18	23
7	Filler – 1	X(2)		24	25
8	Claim Reference Line Number	9(2)	R	26	27
9	Supplemental Record Flag	9(1)	R	28	28
10	Provider Type	9(2)	L	29	30
11	Provider ID Number	9(7)	L	31	37
12	Filler	X(2)		38	39
13	Recipient ID Number	9(8)	L	40	47
14	Carrier Name	X(30)	L	48	77
15	Policy Number	X(16)	L	78	93
16	Contract Number	9(16)	L	94	109
17	Service Codes	X(12)	L	110	121
18	Policyholder Name	X(20)	L	122	141
19	Employers Name	X(20)	L	142	161
20	Last of Claim	9(1)	R	162	162
21	Number of Entries	9(1)	R	163	163
22	History Claim Information (Occurs 4 times)				
22A	Explanation Code	9(4)	R	164	167
22B	Filler	X(3)		168	170
22C	History CRN	9(10)	R	171	180
22D	Filler	X(2)		181	182
22E	History Line Number	9(2)	R	183	184
22F	History Claim ID	9(4)	R	185	188
22G	History Payment Date	9(6)	R	189	194
23	Filler	X(73)		288	360

C1.1 Proprietary Remittance Advice (R866 and R867)

OUTPUT RECORD REMITTANCE ADVICE SUPPLEMENTAL RECORD - R867

FIELD	LOCATION & POSITION	FIELD NAME AND DESCRIPTION
1	1-3 9(3)	**Record Code** A three-character numeric field used to identify the record type. The record code does not appear on the paper Remittance Advice. ***All R867 records have a constant value of "867" in this field.***
2	4-5 9(2)	**Pay Cycle Number** A two-character numeric field used to identify the pay cycle on which the R867 record was produced. The pay cycle number may be found in the upper portion of the paper Remittance Advice under the heading ***"Pay Cycle"***: the pay cycle number is assigned by the Medical Services Administration sequentially to each pay cycle, beginning with 01 for the first pay cycle in the year, and ending with 52 for the last pay cycle in the year. Additional pay cycles will be assigned numbers greater than 52. The pay cycle number is right-justified and left
3	6-9 X(4)	**Billing Agent Number** A four-character alphanumeric field used to identify the entry source of the claim. The claim identifier corresponds to the claim identifier ***(R101-06*)** on the claim reported in this R867 record. The claim identifier may be fund on the paper Remittance Advice under the heading "Claim Reference Number," as the right-most two characters following the Claim Reference Number. The claim identifier is right-justified and left zero-filled.
4	10-10 9(1)	**Previous Pend Flag** A one-character numeric field used to identify whether the claim line (or approved IPH claim) reported in this R867 record is new input on this pay cycle or entered this pay cycle from the pended claims file. The Previous Pend Flag does not appear on the paper Remittance Advice. Valid codes for the Previous Pend flag are as follows: ***0 = new input on this pay cycle*** ***1 = entered to this pay cycle from pend file***
5	11-13 X(3)	**Filler** A three-character alphanumeric field whose value is space.
6		**Claim Reference Number** A ten-character numeric field used to identify the CRN assigned to the claim line (or approved IPH claim) being reported in this R867 record. The Claim Reference Number may be found on the paper Remittance Advice under the heading "Claim Reference Number." The Claim Reference Number corresponds to the Claim Reference Number
6A	14-17 9(4)	**CRN Julian Date** A four-character numeric subfield corresponding to the left-most four characters of the Claim Reference Number on the claim reported in this R867 record.

C1.1 Proprietary Remittance Advice (R866 and R867)

OUTPUT RECORD REMITTANCE ADVICE SUPPLEMENTAL RECORD - R867 (continued)

FIELD	LOCATION & POSITION	FIELD NAME AND DESCRIPTION
6B	18-23 9(6)	**CRN Sequence** A six-character numeric subfield corresponding to the right-most six characters of the Claim Reference Number on the claim reported in this R867 record.
7	24-25 X(2)	**Filler** A two-character alphanumeric field whose value is space.
8	26-27 9(2)	**Claim Reference Line** A two-character numeric field used to indicate the line number of the claim. The claim line number may be found on the paper Remittance Advice under the heading "Line No." The claim line number corresponds to the claim line number (R102-05) on the claim reported in this R867 record. The claim line number is right-justified and left zero-filled.
9	28-28 9(1)	**Supplemental Record Flag** A one-character numeric field used to identify whether this record is an R866 or an R867 record: The Supplemental Record Flag does not appear on the paper Remittance Advice. This field is used by the Medical Services Administration for ease in sorting and is a constant value of “1.”
10	29-30 9(2)	**Provider Type** A two-character numeric field used to identify the type of provider for who the claim was submitted. The provider type may be found in the upper area on the paper Remittance Advice under the heading "Provider Type." The Provider Type corresponds to the provider type (R101-09) on the claim reported in this R867 record.
11	31-37 9(7)	**Provider ID Number** A seven-character numeric field used to identify the provider for whom the claim was submitted. The Provider ID Number may be found in the upper area of the paper Remittance Advice under the heading "Provider ID No." The Provider ID Number corresponds to the Provider ID Number (R101-10) on the claim reported in this R867 record.
12	38-39 X(2)	**Filler** A two-character alphanumeric field whose value is space.
13	40-47 9(8)	**Recipient ID Number** An eight-character numeric field used to identify the recipient. The Recipient ID Number may be found in the body of the paper Remittance Advice to the right of the header "Recipient ID Number." The recipient ID Number corresponds to the Recipient ID Number ***(R101-8)*** on the claim reported in this R867 record.
14	48-77 X(30)	**Carrier Name** A thirty-character alphanumeric field used to identify the name of the insurance carrier, which may cover the services billed. The Carrier Name may be found on the paper Remittance Advice to the right of the header "Carrier." The Carrier Name is left-justified and right space-filled.

C1.1 Proprietary Remittance Advice (R866 and R867)

OUTPUT RECORD REMITTANCE ADVICE SUPPLEMENTAL RECORD - R867 (continued)

FIELD	LOCATION & POSITION	FIELD NAME AND DESCRIPTION
15	78-93 X(16)	**Policy Number** A sixteen-character alphanumeric field used to report the number of the insurance policy, which may cover the services billed. The Policy Number may be found on the paper Remittance Advice to the right of the header "Policy." The Policy Number is left-justified and right space-filled.
16	94-109 9(16)	**Contract Number** A sixteen-character numeric field used to report the number of the insurance contract, which may cover the services billed. The Contract Number may be found on the paper Remittance Advice to the right of the header "Contract Number." The Contract Number is left-justified and right space-filled.
17	110-121 X(12)	**Service Code** A twelve-character alphanumeric field used to report the Service Code of the insurance policy, which may cover the services billed. The Service Code may be found on the Remittance Advice to the right of the header "Services." The service code field is left-justified and right space-filled.
18	122-141 X(20)	**Policy Holder Name** This is the name of the Insurance Policy
19	142-161 X(20)	**Employers Name** This is the name of the Insured holders employer's name.
20	162-162 9(1)	**Last of Claim** A one-character numeric field used to report whether another R867 record for the same claim line follows and whether insurance information ***(fields R867-14 through R867-16)*** exists on this R867 record. The last of claim indicator does not appear on the paper Remittance Advice. Valid last of claim codes are as follows: ***0 = no insurance information; another R867 record for this claim line follows*** ***1 = no insurance information; last R867 for this claim line*** ***2 = no insurance information; last R867 for this claim*** ***3 = contains insurance information; last R867 for this claim***..
21	163-163 9(1)	**Number of Entries** A one-character numeric field used to report the number of occurrences of the history claim information section ***(R867-22*)** which contain information. The Number of Entries indicator does not appear on the paper Remittance Advice. ***Valid codes for the last of claim are all integer values between "0" and "4" inclusive.***

C1.1 Proprietary Remittance Advice (R866 and R867)

OUTPUT RECORD REMITTANCE ADVICE SUPPLEMENTAL RECORD - R867 (continued)

FIELD	LOCATION & POSITION	FIELD NAME AND DESCRIPTION
22		**History Claim Information Section** A one hundred and twenty four -character alphanumeric field, which occurs four times and is used to report any previously approved claim(s) which cause an explanation code to be reported. The History Claim Information Section contains the following subfields:
22A	164-167 9(4)	**Explanation Code** A four-character numeric subfield used to report a condition detected by the IP system on the claim line) reported which is associated with a previously approved claim. The Explanation Code may be found on the paper Remittance Advice under the heading "Explanation Codes or Comments." The Explanation Code will correspond to one of the explanation code occurrences ***(R866-33A*)** in the associated R866 record. The explanation code field is right-justified and left zero-filled.
22B	168-170 X(3)	**Filler** A three-character alphanumeric field whose value is space.
22C	171-180 9(10)	**History CRN** A ten-character numeric subfield used to report the Claim Reference Number (CRN) assigned to the previously approved claim which cause the explanation code in the corresponding explanation code subfield to be reported. The History CRN may be found under the heading "Explanation Codes or Comments" on the paper Remittance Advice.
22D	181-182 X(2)	**Filler** A two-character alphanumeric field whose value is space.
22E	183-184 9(2)	**History-Line-Number** A two-character numeric subfield used to report the line number of the previously approved claim, which caused the explanation code in the corresponding explanation code subfield to be reported. This History Line Number may be found on the paper Remittance Advice under the heading “Explanation Codes or Comments” on the paper Remittance Advice.
22F	185-188 9(4)	**History Claim ID** This if a four-character numeric subfield used to report the entry source of the previously approved claim which caused the explanation code in the associated explanation code subfield to be reported. If the previously approved claim was submitted on magnetic automated file, the Billing Agent ID number will appear in this subfield. The History Claim ID may be found on the paper Remittance Advice under the heading "Explanation Codes or Comments." The History Claim ID is right-justified and left zero-filled.

C1.1 Proprietary Remittance Advice (R866 and R867)

OUTPUT RECORD REMITTANCE ADVICE SUPPLEMENTAL RECORD - R867 (concluded)

FIELD	LOCATION & POSITION	FIELD NAME AND DESCRIPTION
22G	189-194 9(6)	**History Date Payment** A six-character numeric subfield ***(of the format "MMDDYY")*** used to report the date the previously approved claim which caused the explanation code in the associated explanation code subfield to be reported. The History Date of Payment may be found on the paper Remittance Advice under the heading "Explanation Codes or Comments."
23	288-360 X(73)	**Filler** A seventy-three-character alphanumeric field whose value is space.

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C1.2 ANSI X12 835 Remittance Advice (Under Development)

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C2 997 ACKNOWLEDGMENT FILES

C2.1 997 Functional Acknowledgement, Version 3051

997 Functional Acknowledgment

Functional Group ID=FA

Introduction:

This Draft Standard for Trial Use contains the format and establishes the data contents of the Functional Acknowledgment Transaction Set (997) for use within the context of an Electronic Data Interchange (EDI) environment. The transaction set can be used to define the control structures for a set of acknowledgments to indicate the results of the syntactical analysis of the electronically encoded documents. The encoded documents are the transaction sets, which are grouped in functional groups, used in defining transactions for business data interchange. This standard does not cover the semantic meaning of the information encoded in the transaction sets.

	Pos. No.	Seg. ID	Name	Req. Des.	Max.Use	Loop Repeat	Notes and Comments
M	010	ST	Transaction Set Header	M	1		n1
M	020	AK1	Functional Group Response Header	M	1		n2
			LOOP ID - AK2			999999	
	030	AK2	Transaction Set Response Header	O	1		n3
			LOOP ID - AK3			999999	
	040	AK3	Data Segment Note	O	1		c1
	050	AK4	Data Element Note	O	99		
M	060	AK5	Transaction Set Response Trailer	M	1		
M	070	AK9	Functional Group Response Trailer	M	1		
M	080	SE	Transaction Set Trailer	M	1		

Transaction Set Notes

1. These acknowledgments shall not be acknowledged, thereby preventing an endless cycle of acknowledgments of acknowledgments.
The Functional Group Header Segment (GS) is used to start the envelope for the Functional Acknowledgment Transaction Sets. In preparing the functional group of acknowledgments, the application sender's code and the application receiver's code, taken from the functional group being acknowledged, are exchanged; therefore, one acknowledgment functional group responds to only those functional groups from one application receiver's code to one application sender's code.
There is only one Functional Acknowledgment Transaction Set per acknowledged functional group.

2. AK1 is used to respond to the functional group header and to start the acknowledgement for a functional group. There shall be one AK1 segment for the functional group that is being acknowledged.

3. AK2 is used to start the acknowledgement of a transaction set within the received functional group. The AK2 segments shall appear in the same order as the transaction sets in the functional group that has been received and is being acknowledged.

Transaction Set Comments

1. The data segments of this standard are used to report the results of the syntatical analysis of the functional groups of transaction sets; they report the extent to which the syntax complies with the standards for transaction sets and functional groups. They do not report on the semantic meaning of the transaction sets (for example, on the ability of the receiver to comply with the request of the sender).

C2.1 997 Functional Acknowledgement, Version 3051 (continued)

Segment: **ST** **Transaction Set Header**
Position: 010
Loop:
Level:
Usage: Mandatory
Max Use: 1
Purpose: To indicate the start of a transaction set and to assign a control number
Syntax Notes:
Semantic Notes: **1** The transaction set identifier (ST01) is used by the translation routines of the interchange partners to select the appropriate transaction set definition (e.g., 810 selects the Invoice Transaction Set).
Comments:
Notes: 997 FUNCTIONAL ACKNOWLEDGMENT

Data Element Summary

Ref. Des. Attributes	Data Element	Name		
M **ST01**	**143**	**Transaction Set Identifier Code** Code uniquely identifying a Transaction Set 997 FUNCTIONAL ACKNOWLEDGMENT Refer to 003051 Data Element Dictionary for acceptable code values.	**M**	**ID 3/3**
M **ST02**	**329**	**Transaction Set Control Number** Identifying control number that must be unique within the transaction set functional group assigned by the originator for a transaction set The Transction Set Control Numbers in ST02 and SE02 must be identical. The number is assigned by the originator and must be unique within a functional group (GS-GE). The number also aids in error resolution research. For example, start with the number 0001 and increment from there. Use the corresponding value in SE02 for this transaction set.	**M**	**AN 4/9**

C2.1 997 Functional Acknowledgement, Version 3051 (continued)

Segment: **AK1** **Functional Group Response Header**
Position: 020
Loop:
Level:
Usage: Mandatory
Max Use: 1
Purpose: To start acknowledgment of a functional group
Syntax Notes:
Semantic Notes:
1 AK101 is the functional ID found in the GS segment (GS01) in the functional group being acknowledged.
2 AK102 is the functional group control number found in the GS segment in the functional group being acknowledged.
Comments:

Data Element Summary

	Ref. Des.	Data Element	Name		
	Attributes				
M	**AK101**	**479**	**Functional Identifier Code** Code identifying a group of application related transaction sets HC Health Care Claim (837)	**M**	**ID 2/2**
M	**AK102**	**28**	**Group Control Number** Assigned number originated and maintained by the sender SEMANTIC: AK102 is the functional group control number found in the GS Segment in the functional group being acknowledged.	**M**	**N0 1/9**

C2.1 997 Functional Acknowledgement, Version 3051 (continued)

Segment: **AK2** **Transaction Set Response Header**
Position: 030
Loop: AK2 Optional
Level:
Usage: Optional
Max Use: 1
Purpose: To start acknowledgment of a single transaction set
Syntax Notes:
Semantic Notes:
1 AK201 is the transaction set ID found in the ST segment (ST01) in the transaction set being acknowledged.
2 AK202 is the transaction set control number found in the ST segment in the transaction set being acknowledged.
Comments:

Data Element Summary

	Ref. Des.	Data Element	Name		
	Attributes				
M	**AK201**	**143**	**Transaction Set Identifier Code** Code uniquely identifying a Transaction Set SEMANTIC: AK201 is the transaction set ID found in the ST Segment in the transaction set being acknowledged. 837 X12.86 Health Care Claim	**M**	**ID 3/3**
M	**AK202**	**329**	**Transaction Set Control Number** Identifying control number that must be unique within the transaction set functional group assigned by the originator for a transaction set SEMANTIC: AK202 is the transaction set control number found in the ST Segment in the tranaction set being acknowledged.	**M**	**AN 4/9**

C2.1 997 Functional Acknowledgement, Version 3051 (continued)

Segment: **AK3** **Data Segment Note**
Position: 040
Loop: AK3 Optional
Level:
Usage: Optional
Max Use: 1
Purpose: To report errors in a data segment and identify the location of the data segment
Syntax Notes:
Semantic Notes:
Comments:
Notes: The data segments of this standard are used to report the results of the syntactical analysis of the functional groups of transaction setsl they report the extent to which the syntax complies with the standards for transaction sets and functional groups. They do not report on the semantic meaning of the transaction sets (for example, on the ability of the receiver to comply with the request of the sender).

Data Element Summary

	Ref. Des.	Data Element	Name		
	Attributes				
M	**AK301**	**721**	**Segment ID Code** Code defining the segment ID of the data segment in error (See Appendix A - Number 77) This is the two or three characters which occur at the beginning of a segment.	**M**	**ID 2/3**
M	**AK302**	**719**	**Segment Position in Transaction Set** The numerical count position of this data segment from the start of the transaction set: the transaction set header is count position 1 This is the numeric position number of the segment in the Transaction Set with the ST Segment being position 1..	**M**	**N0 1/6**
	AK303	**447**	**Loop Identifier Code** The loop ID number given on the transaction set diagram is the value for this data element in segments LS and LE The loop ID Number given on the Transaction Set Diagramis recommended as the value for this data segment in the segments LS and LE.	**O**	**AN 1/4**
	AK304	**720**	**Segment Syntax Error Code** Code indicating error found based on the syntax editing of a segment This code is required if an error exists. 1 Unrecognized segment ID 2 Unexpected segment 3 Mandatory segment missing 4 Loop Occurs Over Maximum Times 5 Segment Exceeds Maximum Use 6 Segment Not in Defined Transaction Set 7 Segment Not in Proper Sequence 8 Segment Has Data Element Errors	**O**	**ID 1/3**

C2.1 997 Functional Acknowledgement, Version 3051 (continued)

Segment: **AK4** **Data Element Note**
Position: 050
Loop: AK3 Optional
Level:
Usage: Optional
Max Use: 99
Purpose: To report errors in a data element and identify the location of the data element
Syntax Notes:
Semantic Notes:
Comments:

Data Element Summary

	Ref. Des. Attributes	Data Element	Name		
M	**AK401**	**C030**	**Position in Segment** Code indicating the relative position of a simple data element, or the relative position of a composite data structure combined with the relative position of the component data element within the composite data structure, in error; the count starts with 1 for the simple data element or composite data structure immediately following the segment ID	**M**	
M	**C03001**	**722**	**Element Position in Segment** This is used to indicate the relative position of a simple data element, or the relative position of a composite data structure with the relative position of the component within the composite data structure, in error; in the data segment the count starts with 1 for the simple data element or composite data structure immediately following the segment ID	**M**	**N0 1/2**
	C03002	**1528**	**Component Data Element Position in Composite** To identify the component data element position within the composite that is in error Used when an error occurs in a composite data element and the composite data element position can be determined.	**O**	**N0 1/2**
	AK402	**725**	**Data Element Reference Number** Reference number used to locate the data element in the Data Element Dictionary Use when data element number can be determined. The data Element Reference Number fo rthis data element is 725. For example, all reference numbers are found with the segment descriptions in this implementation guide.	**O**	**N0 1/4**
M	**AK403**	**723**	**Data Element Syntax Error Code** Code indicating the error found after syntax edits of a data element 1 Mandatory data element missing 2 Conditional required data element missing. 3 Too many data elements. 4 Data element too short. 5 Data element too long. 6 Invalid character in data element. 7 Invalid code value. 8 Invalid Date 9 Invalid Time 10 Exclusion Condition Violated	**M**	**ID 1/3**
	AK404	**724**	**Copy of Bad Data Element** This is a copy of the data element in error Used to provide a copy of erroneous data to the original submitte, but this is not used if the error reported is an invalid character.	**O**	**AN 1/99**

C2.1 997 Functional Acknowledgement, Version 3051 (continued)

Segment: **AK5** **Transaction Set Response Trailer**
Position: 060
Loop: AK2 Optional
Level:
Usage: Mandatory
Max Use: 1
Purpose: To acknowledge acceptance or rejection and report errors in a transaction set
Syntax Notes:
Semantic Notes:
Comments:

Data Element Summary

	Ref. Des. Attributes	Data Element	Name		
M	**AK501**	**717**	**Transaction Set Acknowledgment Code**	**M**	**ID 1/1**
			Code indicating accept or reject condition based on the syntax editing of the transaction set		
			A Accepted		
			E Accepted But Errors Were Noted		
			M Rejected, Message Authentication Code (MAC) Failed		
			R Rejected		
			W Rejected, Assurance Failed Validity Tests		
			X Rejected, Content After Decryption Could Not Be Analyzed		
	AK502	**718**	**Transaction Set Syntax Error Code**	**O**	**ID 1/3**
			Code indicating error found based on the syntax editing of a transaction set		
			1 Transaction Set Not Supported		
			2 Transaction Set Trailer Missing		
			3 Transaction Set Control Number in Header and Trailer Do Not Match		
			4 Number of Included Segments Does Not Match Actual Count		
			5 One or More Segments in Error		
			6 Missing or Invalid Transaction Set Identifier		
			7 Missing or Invalid Transaction Set Control Number		
			8 Authentication Key Name Unknown		
			9 Encryption Key Name Unknown		
			10 Requested Service (Authentication or Encrypted) Not Available		
			11 Unknown Security Recipient		
			12 Incorrect Message Length (Encryption Only)		
			13 Message Authentication Code Failed		
			15 Unknown Security Originator		
			16 Syntax Error in Decrypted Text		
			17 Security Not Supported		
			19 S1E Security End Segment Missing for S1S Security Start Segment		
			20 S1S Security Start Segment Missing for S1E Security End Segment		
			21 S2E Security End Segment Missing for S2S Security Start Segment		
			22 S2S Security Start Segment Missing for S2E Security End Segment		
			23 Transaction Set Control Number Not Unique within the Functional Group		
	AK503	**718**	**Transaction Set Syntax Error Code**	**O**	**ID 1/3**
			Code indicating error found based on the syntax editing of a transaction set		
			Use the same codes indicated in AK502.		
			Refer to 003051 Data Element Dictionary for acceptable code values.		

C2.1 997 Functional Acknowledgement, Version 3051 (continued)

AK504	**718**	**Transaction Set Syntax Error Code** Code indicating error found based on the syntax editing of a transaction set Use the same codes indicated in AK502. Refer to 003051 Data Element Dictionary for acceptable code values.	**O**	**ID 1/3**
AK505	**718**	**Transaction Set Syntax Error Code** Code indicating error found based on the syntax editing of a transaction set Use the same codes indicated in AK502. Refer to 003051 Data Element Dictionary for acceptable code values.	**O**	**ID 1/3**
AK506	**718**	**Transaction Set Syntax Error Code** Code indicating error found based on the syntax editing of a transaction set Use the same codes indicated in AK502. Refer to 003051 Data Element Dictionary for acceptable code values.	**O**	**ID 1/3**

C2.1 997 Functional Acknowledgement, Version 3051 (continued)

Segment: **AK9** **Functional Group Response Trailer**
Position: 070
Loop:
Level:
Usage: Mandatory
Max Use: 1
Purpose: To acknowledge acceptance or rejection of a functional group and report the number of included transaction sets from the original trailer, the accepted sets, and the received sets in this functional group
Syntax Notes:
Semantic Notes:
Comments: **1** If AK901 is 'A' or 'E', then the transmitted functional group is accepted. If AK901 is 'R', then the transmitted group is rejected.

Data Element Summary

	Ref. Des. Attributes	Data Element	Name		
M	**AK901**	**715**	**Functional Group Acknowledge Code** Code indicating accept or reject condition based on the syntax editing of the functional group Comment, if AK901 contains the value "A" or "E", then the transmitted functional group is accepted. A Accepted E Accepted, But Errors Were Noted. M Rejected, Message Authentication Code (MAC) Failed P Partially Accepted, At Least One Transaction Set Was Rejected R Rejected W Rejected, Assurance Failed Validity Tests X Rejected, Content After Decryption Could Not Be Analyzed	**M**	**ID 1/1**
M	**AK902**	**97**	**Number of Transaction Sets Included** Total number of transaction sets included in the functional group or interchange (transmission) group terminated by the trailer containing this data element This is the value in the original GE01.	**M**	**N0 1/6**
M	**AK903**	**123**	**Number of Received Transaction Sets** Number of Transaction Sets received	**M**	**N0 1/6**
M	**AK904**	**2**	**Number of Accepted Transaction Sets** Number of accepted Transaction Sets in a Functional Group	**M**	**N0 1/6**
	AK905	**716**	**Functional Group Syntax Error Code** Code indicating error found based on the syntax editing of the functional group header and/or trailer 1 Functional Group Not Supported 2 Functional Group Version Not Supported 3 Functional Group Trailer Missing 4 Group Control Number in the Functional Group Header and Trailer Do Not Agree 5 Number of Included Transaction Sets Does Not Match Actual Count 6 Group Control Number Violates Syntax 10 Authentication Key Name Unknown 11 Encryption Key Name Unknown 12 Requested Service (Authentication or Encryption) Not Available 13 Unknown Security Recipient 14 Unknown Security Originator 15 Syntax Error in Decrypted Text	**O**	**ID 1/3**

C2.1 997 Functional Acknowledgement, Version 3051 (continued)

		16	Security Not Supported		
		17	Incorrect Message Length (Encryption Only)		
		18	Message Authentication Code Failed		
		19	S1E Security End Segment Missing for S1S Security Start Segment		
		20	S1S Security Start Segment Missing for S1E End Segment		
		21	S2E Security End Segment Missing for S2S Security Start Segment		
		22	S2S Security Start Segment Missing for S2E Security End Segment		
AK906	**716**	**Functional Group Syntax Error Code** Code indicating error found based on the syntax editing of the functional group header and/or trailer Use the same codes indicated in AK905. Refer to 003051 Data Element Dictionary for acceptable code values.		**O**	**ID 1/3**
AK907	**716**	**Functional Group Syntax Error Code** Code indicating error found based on the syntax editing of the functional group header and/or trailer Use the same codes indicated in AK905. Refer to 003051 Data Element Dictionary for acceptable code values.		**O**	**ID 1/3**
AK908	**716**	**Functional Group Syntax Error Code** Code indicating error found based on the syntax editing of the functional group header and/or trailer Use the same codes indicated in AK905. Refer to 003051 Data Element Dictionary for acceptable code values.		**O**	**ID 1/3**
AK909	**716**	**Functional Group Syntax Error Code** Code indicating error found based on the syntax editing of the functional group header and/or trailer Use the same codes indicated in AK905. Refer to 003051 Data Element Dictionary for acceptable code values.		**O**	**ID 1/3**

C2.1 997 Functional Acknowledgement, Version 3051 (concluded)

Segment: **SE** **Transaction Set Trailer**
Position: 080
Loop:
Level:
Usage: Mandatory
Max Use: 1
Purpose: To indicate the end of the transaction set and provide the count of the transmitted segments (including the beginning (ST) and ending (SE) segments).
Syntax Notes:
Semantic Notes:
Comments: **1** SE is the last segment of each transaction set.

Data Element Summary

	Ref. Des.	Data Element	Name		
	Attributes				
M	**SE01**	**96**	**Number of Included Segments** Total number of segments included in a transaction set including ST and SE segments	**M**	**N0 1/10**
M	**SE02**	**329**	**Transaction Set Control Number** Identifying control number that must be unique within the transaction set functional group assigned by the originator for a transaction set The Transction Set Control Numbers in ST02 and SE02 must be identical. The number is assigned by the originator and must be unique within a functional group (GS-GE). The number also aids in error resolution research. For example, start with the number 0001 and increment from there.	**M**	**AN 4/9**

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C2.2 997 Functional Acknowledgement, Version 4010

997 Functional Acknowledgment

Functional Group ID=FA

Introduction:

This Draft Standard for Trial Use contains the format and establishes the data contents of the Functional Acknowledgment Transaction Set (997) for use within the context of an Electronic Data Interchange (EDI) environment. The transaction set can be used to define the control structures for a set of acknowledgments to indicate the results of the syntactical analysis of the electronically encoded documents. The encoded documents are the transaction sets, which are grouped in functional groups, used in defining transactions for business data interchange. This standard does not cover the semantic meaning of the information encoded in the transaction sets.

	Pos. No.	Seg. ID	Name	Req. Des.	Max.Use	Loop Repeat	Notes and Comments
M	010	ST	Transaction Set Header	M	1		n1
M	020	AK1	Functional Group Response Header	M	1		n2
			LOOP ID - AK2			999999	
	030	AK2	Transaction Set Response Header	O	1		n3
			LOOP ID - AK3			999999	
	040	AK3	Data Segment Note	O	1		c1
	050	AK4	Data Element Note	O	99		
M	060	AK5	Transaction Set Response Trailer	M	1		
M	070	AK9	Functional Group Response Trailer	M	1		
M	080	SE	Transaction Set Trailer	M	1		

Transaction Set Notes

1. These acknowledgments shall not be acknowledged, thereby preventing an endless cycle of acknowledgments of acknowledgments. Nor shall a Functional Acknowledgment be sent to report errors in a previous Functional Acknowledgment.
The Functional Group Header Segment (GS) is used to start the envelope for the Functional Acknowledgment Transaction Sets. In preparing the functional group of acknowledgments, the application sender's code and the application receiver's code, taken from the functional group being acknowledged, are exchanged; therefore, one acknowledgment functional group responds to only those functional groups from one application receiver's code to one application sender's code.
There is only one Functional Acknowledgment Transaction Set per acknowledged functional group.

2. AK1 is used to respond to the functional group header and to start the acknowledgement for a functional group. There shall be one AK1 segment for the functional group that is being acknowledged.

3. AK2 is used to start the acknowledgement of a transaction set within the received functional group. The AK2 segments shall appear in the same order as the transaction sets in the functional group that has been received and is being acknowledged.

Transaction Set Comments

1. The data segments of this standard are used to report the results of the syntactical analysis of the functional groups of transaction sets; they report the extent to which the syntax complies with the standards for transaction sets and functional groups. They do not report on the semantic meaning of the transaction sets (for example, on the ability of the receiver to comply with the request of the sender).

C2.2 997 Functional Acknowledgement, Version 4010 (continued)

Segment: **ST** **Transaction Set Header**
Position: 010
Loop:
Level:
Usage: Mandatory
Max Use: 1
Purpose: To indicate the start of a transaction set and to assign a control number
Syntax Notes:
Semantic Notes: **1** The transaction set identifier (ST01) is used by the translation routines of the interchange partners to select the appropriate transaction set definition (e.g., 810 selects the Invoice Transaction Set).
Comments:

Data Element Summary

Ref. Des.	Data Element	Name		
Attributes				
M **ST01**	**143**	**Transaction Set Identifier Code** Code uniquely identifying a Transaction Set 276 Health Care Claim Status Request 837 Health Care Claim	**M**	**ID 3/3**
M **ST02**	**329**	**Transaction Set Control Number** Identifying control number that must be unique within the transaction set functional group assigned by the originator for a transaction set The Transaction Set Control Number in ST02 and SE02 must be identical. The number is assigned by the originator and must be unique within a functional group (GS-GE). The number also aids in error resolution research. For example, start with the numnber 0001 and increment from there. Use the corresponding value in SE02 for this transaction set.	**M**	**AN 4/9**

C2.2 997 Functional Acknowledgement, Version 4010 (continued)

Segment: **AK1** **Functional Group Response Header**
Position: 020
Loop:
Level:
Usage: Mandatory
Max Use: 1
Purpose: To start acknowledgment of a functional group
Syntax Notes:
Semantic Notes:
1 AK101 is the functional ID found in the GS segment (GS01) in the functional group being acknowledged.
2 AK102 is the functional group control number found in the GS segment in the functional group being acknowledged.
Comments:

Data Element Summary

	Ref. Des. Attributes	Data Element	Name		
M	**AK101**	**479**	**Functional Identifier Code** Code identifying a group of application related transaction sets HC Health Care Claim (837) HR Health Care Claim Status Request (276)	**M**	**ID 2/2**
M	**AK102**	**28**	**Group Control Number** Assigned number originated and maintained by the sender SEMANTIC: AK102 is the functional group control number found in the GS Segment in the functional group being acknowledged.	**M**	**N0 1/9**

C2.2 997 Functional Acknowledgement, Version 4010 (continued)

Segment: **AK2** **Transaction Set Response Header**
Position: 030
Loop: AK2 Optional
Level:
Usage: Optional
Max Use: 1
Purpose: To start acknowledgment of a single transaction set
Syntax Notes:
Semantic Notes:
1 AK201 is the transaction set ID found in the ST segment (ST01) in the transaction set being acknowledged.
2 AK202 is the transaction set control number found in the ST segment in the transaction set being acknowledged.
Comments:

Data Element Summary

Ref. Des.	Data Element	Name		
Attributes				
M **AK201**	**143**	**Transaction Set Identifier Code** Code uniquely identifying a Transaction Set SEMANTIC: AK201 is the transaction set ID found in hte ST Segment in the transaction set being acknowledged. 276 Health Care Claim Status Request 837 Health Care Claim	**M**	**ID 3/3**
M **AK202**	**329**	**Transaction Set Control Number** Identifying control number that must be unique within the transaction set functional group assigned by the originator for a transaction set SEMANTIC: AK202 is the transaction set control number found in the ST Segment in the transaction set being acknowledged.	**M**	**AN 4/9**

C2.2 997 Functional Acknowledgement, Version 4010 (continued)

Segment: **AK3** **Data Segment Note**
Position: 040
Loop: AK3 Optional
Level:
Usage: Optional
Max Use: 1
Purpose: To report errors in a data segment and identify the location of the data segment
Syntax Notes:
Semantic Notes:
Comments:

Data Element Summary

	Ref. Des. Attributes	Data Element	Name		
M	**AK301**	**721**	**Segment ID Code** Code defining the segment ID of the data segment in error (See Appendix A - Number 77) This is the two or three characters which occur at the beginning of a segment.	**M**	**ID 2/3**
M	**AK302**	**719**	**Segment Position in Transaction Set** The numerical count position of this data segment from the start of the transaction set: the transaction set header is count position 1 This is the numeric position number of the error segment in the Transaction Set with the ST Segment being position 1.	**M**	**N0 1/6**
	AK303	**447**	**Loop Identifier Code** The loop ID number given on the transaction set diagram is the value for this data element in segments LS and LE	**O**	**AN 1/6**
	AK304	**720**	**Segment Syntax Error Code** Code indicating error found based on the syntax editing of a segment This code is required if an error exists. 1 Unrecognized segment ID 2 Unexpected segment 3 Mandatory segment missing 4 Loop Occurs Over Maximum Times 5 Segment Exceeds Maximum Use 6 Segment Not in Defined Transaction Set 7 Segment Not in Proper Sequence 8 Segment Has Data Element Errors	**O**	**ID 1/3**

C2.2 997 Functional Acknowledgement, Version 4010 (continued)

Segment: **AK4** **Data Element Note**
Position: 050
Loop: AK3 Optional
Level:
Usage: Optional
Max Use: 99
Purpose: To report errors in a data element or composite data structure and identify the location of the data element
Syntax Notes:
Semantic Notes: **1** In no case shall a value be used for AK404 that would generate a syntax error, e.g., an invalid character.
Comments:

Data Element Summary

	Ref. Des. Attributes	Data Element	Name		
M	**AK401**	**C030**	**Position in Segment** Code indicating the relative position of a simple data element, or the relative position of a composite data structure combined with the relative position of the component data element within the composite data structure, in error; the count starts with 1 for the simple data element or composite data structure immediately following the segment ID	**M**	
M	**C03001**	**722**	**Element Position in Segment** This is used to indicate the relative position of a simple data element, or the relative position of a composite data structure with the relative position of the component within the composite data structure, in error; in the data segment the count starts with 1 for the simple data element or composite data structure immediately following the segment ID	**M**	**N0 1/2**
	C03002	**1528**	**Component Data Element Position in Composite** To identify the component data element position within the composite that is in error	**O**	**N0 1/2**
	AK402	**725**	**Data Element Reference Number** Reference number used to locate the data element in the Data Element Dictionary Used when the data element number can be determined. For example, the Data Element Reference Number for this data element is 725. All references numbers are found with the segment descripton in the implementation guide.	**O**	**N0 1/4**
M	**AK403**	**723**	**Data Element Syntax Error Code** Code indicating the error found after syntax edits of a data element 1 Mandatory data element missing 2 Conditional required data element missing. 3 Too many data elements. 4 Data element too short. 5 Data element too long. 6 Invalid character in data element. 7 Invalid code value. 8 Invalid Date 9 Invalid Time 10 Exclusion Condition Violated	**M**	**ID 1/3**
	AK404	**724**	**Copy of Bad Data Element** This is a copy of the data element in error Used to provide a copy of erroneous data to the original submitter, but this is not used if the error reported is an invalid character.	**O**	**AN 1/99**

C2.2 997 Functional Acknowledgement, Version 4010 (continued)

Segment: **AK5** **Transaction Set Response Trailer**
Position: 060
Loop: AK2 Optional
Level:
Usage: Mandatory
Max Use: 1
Purpose: To acknowledge acceptance or rejection and report errors in a transaction set
Syntax Notes:
Semantic Notes:
Comments:

Data Element Summary

Ref. Des. Attributes	Data Element	Name		
M AK501	**717**	**Transaction Set Acknowledgment Code**	**M**	**ID 1/1**
		Code indicating accept or reject condition based on the syntax editing of the transaction set		
		A	Accepted	
		E	Accepted But Errors Were Noted	
		M	Rejected, Message Authentication Code (MAC) Failed	
		R	Rejected	
		W	Rejected, Assurance Failed Validity Tests	
		X	Rejected, Content After Decryption Could Not Be Analyzed	
AK502	**718**	**Transaction Set Syntax Error Code**	**O**	**ID 1/3**
		Code indicating error found based on the syntax editing of a transaction set		
		1	Transaction Set Not Supported	
		2	Transaction Set Trailer Missing	
		3	Transaction Set Control Number in Header and Trailer Do Not Match	
		4	Number of Included Segments Does Not Match Actual Count	
		5	One or More Segments in Error	
		6	Missing or Invalid Transaction Set Identifier	
		7	Missing or Invalid Transaction Set Control Number	
		8	Authentication Key Name Unknown	
		9	Encryption Key Name Unknown	
		10	Requested Service (Authentication or Encrypted) Not Available	
		11	Unknown Security Recipient	
		12	Incorrect Message Length (Encryption Only)	
		13	Message Authentication Code Failed	
		15	Unknown Security Originator	
		16	Syntax Error in Decrypted Text	
		17	Security Not Supported	
		19	S1E Security End Segment Missing for S1S Security Start Segment	
		20	S1S Security Start Segment Missing for S1E Security End Segment	
		21	S2E Security End Segment Missing for S2S Security Start Segment	
		22	S2S Security Start Segment Missing for S2E Security End Segment	
		23	Transaction Set Control Number Not Unique within the Functional Group	
		24	S3E Security End Segment Missing for S3S Security Start Segment	

C2.2 997 Functional Acknowledgement, Version 4010 (continued)

		25	S3S Security Start Segment Missing for S3E Security End Segment		
		26	S4E Security End Segment Missing for S4S Security Start Segment		
		27	S4S Security Start Segment Missing for S4E Security End Segment		
AK503	**718**	**Transaction Set Syntax Error Code**		**O**	**ID 1/3**
		Code indicating error found based on the syntax editing of a transaction set			
		Use the same codes indicated in AK502.			
AK504	**718**	**Transaction Set Syntax Error Code**		**O**	**ID 1/3**
		Code indicating error found based on the syntax editing of a transaction set			
		Use the same codes indicated in AK502.			
AK505	**718**	**Transaction Set Syntax Error Code**		**O**	**ID 1/3**
		Code indicating error found based on the syntax editing of a transaction set			
		Use the same codes indicated in AK502.			
AK506	**718**	**Transaction Set Syntax Error Code**		**O**	**ID 1/3**
		Code indicating error found based on the syntax editing of a transaction set			
		Use the same codes indicated in AK502.			

C2.2 997 Functional Acknowledgement, Version 4010 (continued)

Segment: **AK9** **Functional Group Response Trailer**
Position: 070
Loop:
Level:
Usage: Mandatory
Max Use: 1
Purpose: To acknowledge acceptance or rejection of a functional group and report the number of included transaction sets from the original trailer, the accepted sets, and the received sets in this functional group
Syntax Notes:
Semantic Notes:
Comments: **1** If AK901 contains the value "A" or "E", then the transmitted functional group is accepted.

Data Element Summary

	Ref. Des. Attributes	Data Element	Name		
M	**AK901**	**715**	**Functional Group Acknowledge Code** Code indicating accept or reject condition based on the syntax editing of the functional group If AK901 contains the value "A" or "E", then the transmitted function group is accepted. A Accepted E Accepted, But Errors Were Noted. M Rejected, Message Authentication Code (MAC) Failed P Partially Accepted, At Least One Transaction Set Was Rejected R Rejected W Rejected, Assurance Failed Validity Tests X Rejected, Content After Decryption Could Not Be Analyzed	**M**	**ID 1/1**
M	**AK902**	**97**	**Number of Transaction Sets Included** Total number of transaction sets included in the functional group or interchange (transmission) group terminated by the trailer containing this data element This is the value in the original GE01.	**M**	**N0 1/6**
M	**AK903**	**123**	**Number of Received Transaction Sets** Number of Transaction Sets received	**M**	**N0 1/6**
M	**AK904**	**2**	**Number of Accepted Transaction Sets** Number of accepted Transaction Sets in a Functional Group	**M**	**N0 1/6**
	AK905	**716**	**Functional Group Syntax Error Code** Code indicating error found based on the syntax editing of the functional group header and/or trailer 1 Functional Group Not Supported 2 Functional Group Version Not Supported 3 Functional Group Trailer Missing 4 Group Control Number in the Functional Group Header and Trailer Do Not Agree 5 Number of Included Transaction Sets Does Not Match Actual Count 6 Group Control Number Violates Syntax 10 Authentication Key Name Unknown 11 Encryption Key Name Unknown 12 Requested Service (Authentication or Encryption) Not Available 13 Unknown Security Recipient 14 Unknown Security Originator 15 Syntax Error in Decrypted Text 16 Security Not Supported 17 Incorrect Message Length (Encryption Only) 18 Message Authentication Code Failed	**O**	**ID 1/3**

C2.2 997 Functional Acknowledgement, Version 4010 (continued)

		19	S1E Security End Segment Missing for S1S Security Start Segment		
		20	S1S Security Start Segment Missing for S1E End Segment		
		21	S2E Security End Segment Missing for S2S Security Start Segment		
		22	S2S Security Start Segment Missing for S2E Security End Segment		
		23	S3E Security End Segment Missing for S3S Security Start Segment		
		24	S3S Security Start Segment Missing for S3E End Segment		
		25	S4E Security End Segment Missing for S4S Security Start Segment		
		26	S4S Security Start Segment Missing for S4E Security End Segment		
AK906	**716**	**Functional Group Syntax Error Code** Code indicating error found based on the syntax editing of the functional group header and/or trailer Use the same codes indicated in AK905.		**O**	**ID 1/3**
AK907	**716**	**Functional Group Syntax Error Code** Code indicating error found based on the syntax editing of the functional group header and/or trailer Use the same codes indicated in AK905.		**O**	**ID 1/3**
AK908	**716**	**Functional Group Syntax Error Code** Code indicating error found based on the syntax editing of the functional group header and/or trailer Use the same codes indicated in AK905.		**O**	**ID 1/3**
AK909	**716**	**Functional Group Syntax Error Code** Code indicating error found based on the syntax editing of the functional group header and/or trailer Use the same codes indicated in AK905.		**O**	**ID 1/3**

C2.2 997 Functional Acknowledgement, Version 4010 (concluded)

Segment: **SE** **Transaction Set Trailer**
Position: 080
Loop:
Level:
Usage: Mandatory
Max Use: 1
Purpose: To indicate the end of the transaction set and provide the count of the transmitted segments (including the beginning (ST) and ending (SE) segments)
Syntax Notes:
Semantic Notes:
Comments: **1** SE is the last segment of each transaction set.

Data Element Summary

	Ref. Des.	Data Element	Name	Attributes
M	**SE01**	**96**	**Number of Included Segments** Total number of segments included in a transaction set including ST and SE segments	**M N0 1/10**
M	**SE02**	**329**	**Transaction Set Control Number** Identifying control number that must be unique within the transaction set functional group assigned by the originator for a transaction set The Transaction Set Control Number in ST02 and SE02 must be identical. The number is assigned by the originator and must be unique within a functional group (GS-GE). The number also aids in error resolution research. For example, start with the numnber 0001 and increment from there.	**M AN 4/9**

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